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A study of therapists' attitudes towards the treatment of seriously suicidal individuals.

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A STUDY OF THERAPISTS' ATTITUDES TOWARDS THE TREATMENT OF SERIOUSLY SUICIDAL INDIVIDUALS

A Thesis Presented

By

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DEDICATION

TO

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C H A P T E R I

INTRODUCTION

Formulation of the Problem

Suicide is a problem. There is a cultural taboo against suicide as there is against other undesirable behaviors such as murder, stealing, and adultery. The act of suicide, thoughts of suicide, and to some extent discussions of suicide are all taboo (Shneidman, 1963). Suicide is still a crime in some states and a sin in some religions. It is grounds for the denial of insurance premiums, and is often labeled insanity in our society (Litman, 1965). The act of suicide is often met with censure, hostility, and condemnation by relatives who typically experience feelings of shame, guilt, and rage. Even when suicide occurs in terminally ill cancer patients who are in great pain, the relatives, friends, and hospital staff often show embarrassment, guilt, and shame (Shneidman, 1963). The taboo against suicide is extensive!

However extensive the taboo is and for whatever reasons it exists, it has not been very effective in solving the suicide problem. Despite the cultural taboo, suicide is still a universal human potentiality and a frequent consideration during emotional crises (Noyes, 1968). A major problem in the United States, the suicide rate exceeds the homicide rate and is the tenth leading cause of death

(Vital Statistics, 1972). People have been killing themselves at a rate of approximately 11/100,000 in the population for the last 20 years (U.S. Vital Statistics). Furthermore, Stengel (1964) estimates that there are six to ten attempts for every completed suicide. This means that the rate of attempted suicides is possibly as high as approximately one per 1,000 in the population. Finally, the reported suicide rate, per se, in the United States is believed to greatly underestimate the extent of the problem (Frederick, 1970). This is due to a lack of uniformity of classification for suicidal deaths in hospitals and by coroners or medical examiners. Also, a general reluctance to admit suicidal intentions of friends or relatives, and/or an inability to recognize it in certain situations undoubtedly results in underreporting.

Mental health professionals and the suicide problem. In all but a few states, the taboo against suicide is no longer backed up by criminal laws against it. Since it is usually considered that normal, healthy, mature people do not logically take their lives, the care of the suicidal people in our society is usually both assigned to and assumed by the group of people identified as mental health professionals.

The mental health professionals have responded to this situation in many ways. First, there has been much research and theoretical formulations on suicide. Farberow's

(1967) Bibliography on Suicide and Suicide Prevention lists over 3300 references on the topic of suicide. There are many sociological, psychological, and socio-psychological theories to explain suicide (Lester, 1972). Second, the magnitude of the problem has led to the founding of over 200 suicide prevention centers, and the American Association of Suicidology with over 500 members. However, the success of these programs, which have saved lives, is uncertain. Lester, for instance, feels the suicide prevention centers have failed due to the problems in identifying and contacting those who are potentially suicidal. He feels most of these centers are involved in crisis intervention and postvention rather than prevention. He also feels that our understanding of suicide itself is limited. However, treatment guidelines and considerations are frequent in the literature (Resnik, 1968; Shneidman & Faberow, 1957; Shneidman, Farberow, & Litman, 1970). In fact, many authorities believe that most successful suicides could have been prevented through an awareness of prodromal clues and appropriate intervention by others during the crisis period. Still, with all this effort, the suicide rate has remained unchanged in the past 20 years. Perhaps the attitudes of the mental health professionals are related to this.

The problem. Frederick (1970), Litman (1968), and Reubin (1973) all have noted that many mental health professionals prefer not to and/or even avoid treating suicidal

people. Given the existence of this attitude among those who are identified as the group to deal with suicide in our society, I would expect that there has been much research on therapists' attitudes. However, the research on suicide has been one-sided, focusing on the suicidal person's personality and social situation, rather than on the treatment situation and the therapists of suicidal people. To quote Kahne (1968), "The psychiatrist whose patient commits suicide is an often discussed, infrequently studied, shadowy figure in contemporary social psychiatry" (p. 42). As for the articles that do address this issue, they are almost entirely "clinical contributions" (Stone, 1964). There are to my knowledge no experimental studies and only a few field studies of relevance. The two relevant field studies are Litman's (1968) interviews of therapists who had recently had a patient who completed suicide and Reubin's (1973) unpublished dissertation, a pioneering effort to explore and study factors he believed were related to psychologists' decisions to treat a suicidal client. Many of Reubin's conclusions, however, are tentative and in need of more study. Also, there are many issues suggested by the non-research literature that might be related to a therapist's attitudes toward treating a client who is a high risk for suicide that have yet to be systematically studied. First, just how many therapists do feel that the treatment of patients who are a high risk for suicide is an undesirable task, a task they

try to avoid? What characteristics of the treatment situation itself contribute to making it an undesirable task? Finally, how are different ratings of desirability of the treatment situation related to certain personal and professional differences among therapists on such factors as experience and personal attitudes toward suicide?

Purpose of the Study

Although the literature on suicide addresses the undesirable aspects of treating a suicidal client, and states that many therapists prefer not to and/or even avoid treating suicidal clients, there has been no experimental study and only one field study (Reubin, 1973) that partially addresses this topic. Thus, this research provides a descriptive field study to explore the attitudes of mental health workers towards the process of psychotherapy with patients who are a high risk for suicide.

I specifically refer to "high risk or seriously" suicidal patients as many clinicians make a division between suicide attemptors and completors (Stengel, 1964), and/or likewise between the manipulative or not serious threateners who occasionally make mild attempts and those who seriously want to kill themselves.

This study focuses on the clinical psychologist and the psychiatrist as the populations of mental health profession-

als to be studied. Other professionals, such as social workers, and the clergy who treat suicidal clients, were excluded to limit the scope of this study. However, the inclusion of psychiatrists in the study allows increased generalizability of any results similar to those of Reubin's study, which sampled only psychologists.

Specifically, the goals of this research are (1) to assess how undesirable the treatment process is rated by mental health professionals who are supposedly responsible for treating suicidal clients; (2) to investigate which aspects of the treatment situation of those suggested by the literature contribute to making it undesirable; and (3) to identify individual differences of professional experience with and personal feelings about suicide that are associated with differential ratings of desirability of treating a seriously suicidal client.

The results of this study provide insight and clues as to which aspects of the treatment situation influence therapist's overall attitude about the treatment of seriously suicidal clients. The objective data (such as amount and types of professional experience) about the therapists suggest why some therapists find various aspects of treatment less undesirable than other therapists. Hopefully this information will be useful for practicing clinicians as well as those in training. Finally, it might stimulate more research.

CHAPTER II

REVIEW OF THE LITERATURE

Treating Suicidal Clients, an Undesirable Task

It is often implied or stated in the literature that many mental health professionals find the suicidal population very undesirable as candidates for treatment. In fact, some authors state that many psychotherapists avoid treating them (Reubin, 1973; Farberow, 1962; Litman, 1968; Hendin, 1961). The following review of the literature will present some aspects and issues of the treatment process that could and often do make it an undesirable task. Included in this review are comments and information about how a therapist's professional experiences may also be related to ratings of desirability. The context areas are (1) the therapists' attitudes towards responsibility for and during treatment; (2) the difficulties of therapeutic process with seriously suicidal clients; and (3) the fears, anxiety, and concern connected with the possible completed suicide of a client.

The mental health professionals' attitudes about responsibility are a mixture of their personal philosophy and professional standards. The demands for provision of treatment, the difficulty of such philosophic questions as one's right to suicide, and the responsibility for preventing self-destruction are complex issues for the therapist of suicidal clients. Motivation to provide treatment and pre-

vent suicide may also be connected to the therapists' feelings about suicide from a personal point of view.

How comfortable a therapist feels in treating suicidal clients is influenced by his confidence in his ability. Also, suicidal patients are seen to be more difficult as they usually require extra effort and time. The threat of suicide often arouses feelings of anxiety, fear, and concern in the therapist. Even skilled therapists often find diagnosis and planning of treatment to be difficult under such pressure.

The experience or knowledge of the effects of a completed suicide of a client certainly are thought of as undesirable by therapists. There are feelings of pain, sadness, anguish, terror, and disbelief. Not uncommon are episodes of depression and hopelessness, lack of confidence, guilt, and anger. In addition, many believe that a client's suicide represents both a professional and a personal failure and they fear blame from relatives and friends of the client as well as professional criticism. Such fears can certainly make the task of treatment with a patient who is a high risk for suicide undesirable if not objectionable.

Attitudes towards Responsibility

Provision of treatment. The societal role of mental health professionals suggests that they are responsible for

dealing with seriously suicidal people. But, this is a norm, not a law. The decision to consider, refer, or accept a client for therapy is still a personal one of free choice for each individual therapist. Some therapists may feel no obligation even to consider all clients, let alone accept them all, or at least provide a referral. This basic question of responsibility is possibly connected to the more difficult questions of responsibility associated with the treatment process of suicidal clients, such as the client's right to suicide, the responsibility for prevention, and the responsibility for restrictive measures such as hospitalization.

The right to suicide. Once a client is accepted for therapy and is or becomes a serious risk for suicide, the question of their right to take their own life must be addressed. The therapist must be clear about his own philosophy and feelings on a person's right to suicide, and what part the therapist himself will have in that decision.

Our society is usually described as being a democracy, where one's individual rights are esteemed and insured. However, this does not include the right to take your own life. A taboo against suicide exists in the U.S. This paradox is an influential factor in the development of one's personal philosophy of life. It is important for a psychotherapist, who often must deal with suicidal patients, to resolve this paradox.

Many therapists draw upon existential philosophers in developing their own attitudes toward life, death, and suicide. The question of suicide is recognized by these therapists to be a major issue of importance for a philosophy of life. Basescu (1965) starts his discussion of psychotherapy and suicide with quotes that emphasize this. "There is but one truly serious philosophical problem, and that is suicide" (Camus, 1955). ". . .[T]he fact that suicide is always possible is the essential starting point of any genuine metaphysical thought (Marcel, 1961). Litman (1968) quotes May (1958) who doubts "whether anyone takes his life with full seriousness until he realizes that it is entirely within his power to commit suicide." Litman himself goes on to state,

> . . .death is inevitable for everyone, . . .no therapist can prevent it eventually,. . .suicide has a certain existential moral value in that the possibility keeps one conscious of being vital and responsible (p. 358).

Thus, suicide can be pondered with great equanimity when thought of philosophically. But the peaceful detachment of such abstract thinking fades when therapists face the problem of integrating philosophic attitudes with psychotherapeutic goals. Litman (1968) states that neither he nor his colleagues ever interviewed a therapist who expressed the idea that the suicide of his patient was philosophically acceptable to him or congruent with the theory

and goals of psychotherapy. Is there a conflict between the existential philosophic attitude and the role of the therapist in society?

Motto (1972) states that medical doctors and psychiatrists share a tradition of commitment to the preservation of human life. Personally, this writer thinks it can be safely assumed that a similar commitment is shared by many psychologists and others who treat suicidal patients in psychotherapy. For instance, Basescu (1965) feels that the psychotherapeutic process is in every instance a "battle against lives of self-destructiveness," although the outcomes infrequently end in suicide. Contrast this attitude with the existential philosophy also advanced by Basescu. That is, man must bear the existential burden of giving life meaning and value. Our consciousness allows us freedom, creativity, and culture, but also entails responsibility, guilt, and anxiety. If the latter burden is too great, we can choose to deny our consciousness through suicide. In a therapeutic relationship, both the therapist and suicidal patient exercise their existential freedom (and burden) of choice when resolving feelings about suicide (Motto, 1972).

If there is a problem of philosophy for the therapist, it can best be expressed by the question: Does a patient have the right to commit suicide? Motto (1972) addresses this question and offers an answer that helps integrate personal philosophy and professional responsibilities. Motto

(1972) addresses this question and offers an answer that helps integrate personal philosophy and professional responsibilities. Motto states unequivocally that people do have the right to suicide. The problem is not having the right, but in deciding to what extent the right should be subject to limitations. Motto proposes two criteria for limiting this right. One, the act must be based on a realistic assessment of the person's life situation, and not clouded by emotional or irrational distortion. It is the therapist, however, who must determine what is their reality. He must use his own perception of reality as a standard, interfering if the patient's assessment is unrealistic. Mintz (1968) makes a similar statement. He asks us to consider if the right to suicide extends to

> the alcoholic in delirium traumas who wishes to jump out of a second story window to escape the pursuing animals he sees. . . . The suicidal patient feels trapped in a room out of which he sees only one door, marked suicide. . . .[W]hen the psychotherapist has freed the patient from emotional myopia and restored to him the possibilities of his life and the freedom to assess them more realistically, it is most rare that the patient chooses suicide (p. 276).

Motto gives the examples of altruistic self-sacrifice and advanced physical illness as conditions he would consider realistic reasons for suicide. Motto also states that the patient must express no ambivalence about his decision. Motto considers phone calls, requests for therapy, or any

other ways of calling attention to the suicidal impulses as a request to intercede in the face of ambivalence.

Although Motto's limits on the right to suicide seem rather extensive and rely on the arbitrary decision of the therapist, he advocates a campaign to break the taboo and social stigma attached to the act of suicide, otherwise, the right originally granted is, in reality, denied again. His program includes setting up criteria-controlled procedures for the voluntary cessation of life such as those we now have for abortion.

There are additional factors, not specified by Motto, that might be considered in limiting one's right to suicide. Suicide can be considered a violation of the trust of life (Jacobs, 1971) and thus harmful to the fabric of society. Also it can be a way of avoiding interpersonal responsibility or an act of aggression that provokes guilt in the living. It can be concluded at this point that the task of deciding if one has the right to suicide can be complicated, and for some, very undesirable.

Responsibility for prevention of suicide. If you, as a therapist, do accept the responsibility for deciding, there is still the problem of whether you have the right to enforce those limits and in what way. Motto's proposal gives the responsibility of intervening in another's life to the therapist. Most writers are in agreement with Motto. For example, Lesse (1965) states that therapists are "ines-

capably responsible" for all severely ill patients. Therapists are reluctant to accept this heavy responsibility of prevention of suicide which, when accepted, causes much anxiety. When the necessity for intervention becomes so extreme as to require hospitalization and/or physical restraint, the ambivalence of the therapist's feelings in regard to the responsibility for another's life become quite apparent.

Basescu (1965) states that the therapist should be reserved in recommending institutionalization. Physical death should be risked to some extent before risking the possible psychological death due to institutionalization. Tenanbaum (1964) states that he "loathes" to suggest institutionalization. The therapist's responsibility does not include the assumption of authority to manage another's life around the complicated and personal subject of life and death. All of us have committed suicide in thought, but few of us are locked up for it.

A quote for Rotov (1970) makes clear the difficulty of accepting the responsibility often assigned to our profession by society.

> Psychiatrists, when they stop to think about it, find it difficult to rationalize the limitation of freedom of a suicidal nonpsychotic patient. It seems as if in the minds of many, occasional loss of life is preferable to the organized control of one group over the other, even for the noble cause of preserving mental health (p. 222).

Professional responsibility and personal attitudes toward death and suicide. Despite the difficulties and complexities of resolving the philosophic and professional problem of suicide, I would have to agree with Hammer (1972) who states that a therapist must have a clear and meaningful philosophy of life and death to constructively relate to suicidal and/or depressed clients. If a therapist's own attitude about death and suicide is a problem in his life, and further if either is viewed with fear and anxiety, the therapist will be likely to not want the responsibilities of treatment of a seriously suicidal client. Even if a therapist accepts the responsibilities, if he fears suicide, he may forget to ask certain questions of a client that are important for proper management and prediction. Direct, open, and frank discussions of the client's life and philosophy, especially fantasied reactions of the survivors, concepts of death, etc., are needed. Furthermore, professional and personal fears of suicide may keep the therapist from considering suicide as adaptive or self-realizing. Therapist anxiety may even lead to premature hospitalization of the client (Mintz, 1968; Noyes, 1968). However, the absence of fears or other emotional conflicts about death and suicide does not necessarily imply the existence of a positive evaluation of suicide or death. In fact, Reubin (1973) found that psychologists who were "more willing" to treat suicidal clients rated both suicide and death in more nega-

tive and critical terms than did "neutrally willing psychologists." Anecdotal data suggested "more willing" psychologists were more likely to be committed to life and see suicide as an unnecessary loss. The "neutrally willing" psychologists, more often, could see death as a problem solver and condone suicidal deaths. Reubin concluded that the "more willing" psychologists were not frightened, but motivated to accept the risks and responsibilities of treatment. They recognized a great need for, and potential benefit of therapeutic intervention and perceived treatment as a rewarding and satisfying endeavor. The threat of suicide seemed to stimulate a greater sense of responsibility to accept and intervene via psychotherapy.

Perhaps the less negative, and sometimes positive evaluation of death and suicide by those who are less motivated to treat suicidal clients is related to unresolved conflicts or traumas about death and suicide. Litman (1968) found that denial of responsibility, rationalization, and repression were commonly used by therapists to reduce unpleasant affects after the suicide of a client. Likewise, one hypothesis might be that an "accepting" philosophic approach to death and suicide allows therapists to feel less obligated to deal with a subject with which they are emotionally uncomfortable.

Treatment of the Suicidal Patient

In the last section, it was stated that philosophical equanimity often gives way to uncertainty and ambivalence when considering one's professional responsibility for treatment of a suicidal patient. However, ambivalence gives way to anxiety when the responsibility for treatment is accepted.

Many writers are quick to acknowledge that the threat of suicide in psychotherapy causes them great concern and anxiety. It also serves to complicate and restrict the psychotherapeutic process (Litman, 1965; Tenenbaum, 1964; Carter, 1971a).

To quote Farberow (1957):

> Probably no single event in the course of psychotherapy carries so much emotional impact and requires so much skill, knowledge, sensitivity, ability, and fortitude on the part of the therapist as a suicidal crisis in his patient (p. 119).

The necessity of the right therapeutic response is heightened by the stakes involved. In conflict with the necessity of a carefully chosen, "right" decision, there is a sense of urgency that demands quick action. Thus the demands on the therapist to be an "expert" in understanding and predicting behavior are increased. Noyes (1968) states that ever since the Middle Ages, the care of the suicidal has been given to those in the "healing arts." Thus, in the

role of therapist, one is responsible for accurately predicting suicide and then preventing it.

Perceived ability and beyond. If a therapist feels that his ability (skills and knowledge) to treat seriously suicidal clients is poor or insufficient, he will probably not desire to engage in the treatment process (except for supervised educational purposes). The question to ask now is, how realistic is an expectation that the therapist be an expert, capable of understanding and prediction of suicidal behavior? Mintz (1968), Klugman et al. (1965), and Litman (1968) feel it is professionally expected that the therapist should be able to recognize possible suicide, evaluate possible risk, and recommend treatment. Mintz points out that although psychotherapy with the suicidal patient involves the therapist with people differing greatly in types of emotional problems requiring a diversity of approaches, there is a large and growing body of knowledge regarding suicidal behavior that generalizes to all suicidal patients. He feels all psychotherapists should be aware of this. Mintz's review of the literature offers guidelines for assessment and reassessment of risk and lists important considerations for therapy and management. Mintz feels that suicide is most often predictable, therefore, it is a tragedy of great magnitude.

Yet some professionals doubt that the therapist's expertise in this area is well refined and feel uncertain when

dealing with suicidal patients. Hirsch and Dunsworth (1973) state that patients often express suicidal ideas. However, it is difficult to estimate how serious different cases may be. Any therapist who deals with suicidal patients must attempt to deal with the "vexing practical problem" of identifying individuals with a high suicide potential (Tuchman & Youngman, 1963, p. 190). This is so because there are up to an estimated ten suicide attempts for every completed suicide and clinical decisions about treatment depend on differentiating people according to risk (Stengel, 1964). It is the opinion of the experts in the field of suicide that there are a number of clues to alert the therapist to the danger of a suicide attempt (Mintz, 1968; Shneidman, 1967; Shneidman & Mandelkorn, 1970; Shneidman & Farerow, 1957). The clinician uses his/her judgment, insights, and experience while taking into account some reliable correlates of suicide such as age, depression, loss of self-esteem, stresses in the external environment, previous attempts and method of attempt, degree of suicidal thoughts, etc., in reading a decision about the suicidal risk of the person. Still, it is a human decision. Furthermore, if the case is estimated to be serious, it may be very difficult to prevent it. Experienced clinicians often relate feelings of failure when talking about past suicidal cases in which they do not see how they could have prevented the fatal outcome. For example, Hirsch and Dunsworth (1973) reviewed 35 cases

of suicide in the care of nine different psychiatrists in the Halifax area. "Thirty-three of them were, in the psychiatrists' opinions, unpreventable except by superior clinical judgment or by an ability to see the future" (p. 108). In addition, some described patients they were currently treating who were estimated to be seriously suicidal and with whom they felt helpless.

The point is that some suicides are preventable, but many experienced clinicians will have some patients for whom they have no remedy. Doubt and anxiety stem from having no guarantee against suicide (Litman, 1968). A quote by Perr (1965) emphasizes this point:

> The causes and means of prevention of this act of complex etiologies (suicide) are not yet defined, not by its nature does any absolute solution seem likely. Suicide remains prominent not only in hospital patients but in office patients, and not only in those under care, but throughout society in general (p. 636).

In summary, not all therapists agree as to how much of an expertise is possible in the area of suicide management and treatment. Obviously, the amount and quality of training and experience of a therapist varies. Thus, it is fairly certain that therapists' perceptions of their ability (skills and knowledge) will differ. In addition, going beyond technical expertise, therapists work under special stresses when dealing with suicidal patients. They face a sense of urgency, a great responsibility, increased personal

anxiety, increased personal effort and involvement, and the contagiousness of the patient's own panic and pessimism. Considering all of this, it is no surprise that certain tasks (such as estimating risk, and deciding how best to prevent a suicide) are likely to be perceived as difficult (apart from ability level), in the treatment process.

Treatment is difficult. Although how difficult one finds or perceives a task to be is related to one's level of ability, I feel that there are certain aspects of the treatment process with patients who are a high risk for suicide that make it difficult regardless of one's level of ability. Just how difficult a task different therapists believe it is, however, will most likely vary.

Few, if any, writers on suicide find the process of therapy an easy task. Litman (1965), Tenenbaum (1964), Carter (1971a), and Fargerow (1957) all speak of the great emotional stress and pressure put on the therapist in a suicidal crisis. Suicidal threats can cause extreme reactions in people. They have the effect of arousing reactions of sympathy, anxiety, anger, hostility, guilt, grief, etc., in friends, relatives, spouses, and therapists (Farberow et al., 1970; Litman, 1968). The therapist often experiences self-doubts about his competence which is weighted by feelings of responsibility for the outcome.

Although the therapist may loose sleep, he must be able to manage his anxiety, lest he transmit it back to the

patient, who is often dependent on the therapist and might loose his confidence of being helped. The therapist must not let his anxiety over suicide interfere with the necessity of inquiring deeply into the subject of suicide with the patient. Such information is necessary for estimating the risk of suicide as accurately as possible. Also, anxiety must not be allowed to drive the therapist to prematurely hospitalize his patient (Noyes, 1968). Thus, one difficulty is dealing with the personal anxiety and emotional stress often precipitated by a suicidal crisis in therapy.

Difficult clients. If the therapist can manage his anxiety he must be able to carry the burden of dealing with some difficult clients. The burdens include weathering the hostile patient who uses suicide sadistically, feeling the act would be a bad reflection on your skill and reputation (Tenenbaum, 1964). There is the patient who uses a suicidal threat to gain your sympathy and/or place endless demands on your time, compassion, and ability to help. Their tactics include anxiety-producing middle of the night calls that can reach the point of blackmail, i.e., when will the threat become reality? Tenenbaum (1964) feels that this greatest concern is aroused by the patients whose life problems are so horrendous that they have given up the struggle. Suicide seems like the logical out. These patients have often suffered defeats in major adjustments (social, marital, and vocational) and death appears to be preferable to the despair

of living. Even when these patients do not speak of suicide, the therapist envisions the possibility and anxiety and dread are aroused in him.

Increased demands on the therapist. The treatment of seriously suicidal cases usually places more demands and responsibilities on the therapist than clients with other types of problems. Litman (1957) states that a different approach must be taken from the beginning for outpatient treatment. The therapist must extend himself psychologically and emotionally, providing sympathy, support, hope and time. Unlimited personal commitment, in the face of anxiety over suicidal behavior, must be directed at accelerating the formation of a good therapist-client relationship and/or dependency transference (Basescu, 1964; Litman, 1957; Rotov, 1970; Stone, 1971; Tabachnik, 1961; Mintz, 1968). This extended support may include increased length and number of sessions, increased therapist activity in the sessions, 24-hour availability, contacts with relatives, and other types of social environmental interventions. The point is that the risk of suicide is minimized by a good therapist-patient relationship and treatment is more effective when the therapist is more personally involved. Both Tenenbaum (1964) and Moss and Hamilton (1957) had patients report that they were about to commit suicide when they thought of their therapist. They felt that they could not let the therapist down. Litman (1957) states that if the

client shows no emotional response to the therapist or is "emotionally bankrupt" with no personal or social assets whatsoever, then the risk of suicide is greatly increased.

Completed Suicide, Possibility and Reality

Treatment can be dangerous. The most undesirable aspect of treatment is the realistic possibility that a seriously suicidal patient may actually succeed in killing her/himself. There are many professional fears associated with the possibility of a patient's suicide. One fear during treatment is that the therapist may make an error in her/his judgment that is fatal to the client. Worse, maybe, is the fear that the actions of the therapist in therapy may precipitate the suicide of a client.

Are some suicides precipitated by psychotherapy and/or the therapist? It should be noted that the suicide literature is somewhat barren in respect to this issue (Stone, 1971). Stone suggests a strong taboo exists in this area due to anxiety over malpractice suits and reluctance to make public a touchy professional issue. Besides attempts to assert that psychotherapy causes anything, good or bad, is extremely difficult. Researchers who have attempted to examine the doctor-patient relationship in cases of suicide have often met with considerable resistance (Bloom, 1967; Stone, 1971; Rotov, 1970).

However, of those who have done research or offered personal experiences or opinions, the conclusion is that the mismanagement of therapy with a suicidal client, especially on the issues of transference and countertransference reactions, can in fact be responsible for the precipitation of suicide (Rotov, 1970; Stone, 1971; Litman, 1957; Carter, 1971a; Litman, 1970; Bloom, 1967; Tabachnik, 1961; Wheat, 1960; Mintz, 1968). Acknowledgement of this fact may make some therapists reluctant to treat suicidal clients. Certainly, it raises the anxiety level of those who do treat suicidal clients.

Rotov (1970) suggests that certain personality traits of a therapist can be detrimental to the therapy process and precipitous of suicide actions in many suicidal patients. Doctors who are themselves depressed, have little to offer a patient who reflects their own covert impulses. A benevolent, indecisive, meek therapist too often lets his sentiments get in the way of the proper course of treatment if it is unpleasant for the patient. The patient soon perceives the lack of direction and support from the therapist, realizing he is on his own. An aggressive nihilistically-oriented therapist, who must spend all his energy managing his own aggression, often does little beyond the routine, and is usually unreceptive to advice or criticism. Another type is the therapist who holds a strict philosophical point of view that the neurotic patient is capable of recovery if

he decides to make the effort. Thus, an unimproving neurotic would be a source of unwanted irritation to the doctor.

Besides personality types there are many therapeutic techniques which can be "fatal!" Stone (1971) presents three types of "malignant" psychotherapy which when used with the psychotic patient leads them to a situation characteristic of a seriously suicidal patient. These techniques, "externalizing the superego, interrupting the autistic defense, and the symbiotic transference" all force the patient to see his reality as devoid of possible gratifications in a context of insight that leaves them hopeless and helpless to change it. Stone feels that these particular techniques are three of many overlapping constellations that could be "malignant." Obviously, extra care must be taken for suicidal patients. For example, Carter (1971a) describes several conditions under which the termination of therapy is likely to precipitate suicide for particular patients. For example, a schizophrenic patient who has broken away from a schizophrenic family, yet has not established any other relationships outside of therapy. Such techniques and conditions as described by Stone and Carter are not the most common or troublesome of problems that occur in the psychotherapy of a suicidal patient. Therefore, this brief paragraph should suffice to note their existence.

Of most importance are the frequently occurring difficulties of transference and countertransference reactions.

This issue warrants a more detailed description and discussion. The only quantitative estimate of the magnitude of the transference-countertransference problem that this author is aware of is a statement made by Litman (1970). He estimates that about ten percent of the completed suicides in Los Angeles had talked with a psychiatrist or other mental health specialist within two months of their deaths. For the majority of these cases, a meaningful therapeutic relationship involving transference and countertransference reactions existed. The suicide of those in therapy occurred with great regularity at time of separation due to vacation, termination, interruption of therapy, or upon hospital discharge. The therapists agreed that the clients often felt abandoned, or that therapy was hopeless. For example, over one-third of 1700 night calls received by the Los Angeles Suicide Prevention Center in 1963 were from those currently in therapy. Often they related feelings of being abandoned such as, "My doctor is tired of me," or "He doesn't want to see me anymore," or "I don't want to impose on him any longer." In addition, some expressed anger, wanting to "show the doctor" or "make him feel sorry" (Litman, 1970, p. 300).

The terms transference and countertransference are often given different meanings by different writers. Rotov (1970) examined therapist recorded case materials in hospital files of patients who had committed suicide while in

therapy. He noted examples of both positive and negative countertransference which, he concluded, clearly contributed to the suicide. He did not imply, however, that the therapists were re-experiencing a particular neurotogenic relationship from their childhood. Rather, he suggests that the therapist's dominant emotional attitude was unprofessional, determined by the therapist's needs, and not the patient's.

Other writers use the terms transference and countertransference in a psychoanalytic sense (Bloom, 1967; Tabachnick, 1961). Often suicidal patients have never developmentally achieved a satisfactory relationship with their mothers and thus have feelings of oral deprivation. They usually have a strong, passive, and oral orientation in interpersonal relationships. Thus, with a therapist they often develop hostile and dependent transferences. In this situation, suicide is often precipitated by a symbolic re-experiencing of a rejecting mother figure, the therapist! The rejection can occur as a countertransference reaction by the therapist.

Countertransference hostility is denied, suppressed and/or repressed as it is unacceptable to the therapist. Countertransference reactions are often revealed by a lack of awareness by the therapist of the patient's hostility and self-destructive potential. Such lack of awareness could lead to a faulty diagnosis of a mild, non-suicidal de-

pression rather than a more severe depression involving suicidal tendencies (Bloom, 1967). In therapy, Bloom suggests that, due to a countertransference reaction, a therapist being unconscious of his hostile feelings might permit a suicide to take place to get rid of the irritation.

Litman (1957), Mintz (1968) and Bloom (1967) state that due to a countertransference crisis, the therapist may emphasize and/or overinterpret the provocative, infantile, and hostile nature of the patient's transference reaction, negating a desperate appeal for love and protection. Bloom's (1967) study describes in detail the therapist-client relationship of six suicides which occurred while in treatment. In each case, the suicide was precipitated by rejecting behaviors by the therapist such as angry tone of voice, criticism of the patient, reduced number of visits, less available therapist support, and/or premature hospital discharge. There are many ways the therapist may be rejecting.

In this discussion of countertransference hostility, it should be noted that suicide threats elicit anger from the therapist in many ways. The anger may be a response to suicidal threats which are hostile manipulations directed at the therapist. Suicide threats also indict the therapist as a failure in dealing with the patient's problems. This indictment leads to guilt which may result in anger at the patient.

Thus, it is possible for a therapist and/or the treat-

ment process to precipitate suicidal behavior. As stated before, acknowledgment of this fact may make some therapists reluctant to treat suicidal patients. Certainly, it raises the anxiety level of those who do treat suicidal patients in psychotherapy. To help deal with this anxiety Rotov (1970), Tabachnick (1961), Bloom (1967), and Peer (1968) recommend consultation with another therapist and/or team work when working with a suicidal client. In consultation the therapist's feelings can be properly evaluated and the correct therapeutic strategy can be recommended.

Skillful and experienced therapists check themselves on such issues as countertransference and use this information skillfully in therapy. For example, once aware of countertransference hostility, a therapist can acknowledge negative feelings and point out how they arose to help the patient gain insight into his self-defeating behaviors. The patient may come to realize that his hostility and depression continue because his behavior drives people away, perpetuating his deprivation of love. The pattern is a chain of hostility and rejection. Also, if the therapist is free to express his hostile feelings in a constructive manner, he is also more accepting. This process leads to raising the self-esteem of the patient.

In conclusion, although there are dangers in treating a suicidal patient, many therapists are willing to face them. The descriptions of transference and countertransfer-

ence along with "expert" ways of dealing with them are testimony to this. In the next section, the worst stress and biggest hazard of dealing with a suicidal patient is described, the death of the patient by suicide!

The trauma of death. The intensity of the therapist's personal reaction to the loss of a patient by suicide is dependent on the length of therapy, the amount of professional commitment involved, and the closeness felt in the interpersonal relationship (Carter, 1971; Litman, 1965). Although it is not a hard and fast rule, it is often the case that the longer the treatment, the greater the professional and personal involvement of the therapist. Given that the intensity of the reaction will vary, most writers agree that the emotional experience which occurs when the therapist is first informed of a client's suicide is traumatic (Carter, 1971; Kahne, 1968; Light, 1972; Litman, 1965; Perr, 1968). There are feelings of shock, pain, sadness, anguish, terror, and disbelief. Not uncommon are episodes of depression and hopelessness, lack of confidence, guilt, and anger. A quote by Perr (1968) relating his own personal experience reveals just how intense some of these emotions can be. Perr had just lost a long-term client from his private practice.

> . . .it was with disbelief and shock that I learned about Jack's death. . . . After all the years of effort, agony, and expenses, I had failed. I was filled with grief, guilt, and self-recriminations,

> and reviewed all the steps I should have taken. . . . And I blamed myself for the act he had taken. And in the intense guilt that I experienced, I felt that there would be certain punishment to come. I anticipated charges of incompetence. . . . It was having to leave town, shunned like a leper. . . . I jumped at an opportunity to present a paper on the whole problem of suicide, as an act of restitution. I revived him in fantasies and dreams, feeling momentarily relieved . . . . The grief, guilt, and hurt pride gradually subsided, but did not quite totally disappear. . . realized that in part I needed a jury of colleagues to bring back a verdict of 'not guilty' to agree with me that what had taken place was inevitable . . .(p. 177).

What are the issues and psychological dynamics involved in the resolution of this crisis situation? Carter (1971) and Litman (1965) state that the first and formost psychological mechanism of defense used in this initial stage is denial and/or repression. Therapists often find it difficult to accept the fact that the client is dead. They question whether the death was a suicide. They may forget details of the case history or relevant case features. Carter (1971) feels that during this initial stage it is important for the therapist to receive factual information from objective sources that are non-partisan to either therapist or client. A non-partisan source prevents distortion and/or blame, provides structure to fantasy, and serves to direct attention to reality factors, providing relief from emotional stress. Without information both denial and fantasy may occur destructively.

Grief and mourning periods are sometimes observed in

therapists who lose clients they had liked and/or with whom they had long therapeutic relationships. Litman noted some therapists to have reported symptoms of partial identification with the deceased client, i.e., accident proneness in the weeks immediately following the event. These reactions must be lived through before an objective resolution can be attained.

Carter (1971) feels that unresolved guilt presents the greatest danger of damaging the therapist both as a person and as a therapist. Indeed, a client's suicide is a direct indictment of both the therapy and the therapist as failures (Carter, 1971; Kahne, 1968; Light, 1972; Litman, 1965; Tenenbaum, 1961). Probably the worst manifestation of guilt is a need for punishment. Both Litman (1965) and Carter (1971) report that in critical periods of the resolution stage, therapists sometimes have suicidal fantasies, engage in physically harmful behaviors, and are known to become accident prone.

Guilt may also lead to a loss of self-assurance in therapy. Kahne (1968) found that therapists who had recently lost a patient through suicide advocated more surveillance of patients, more chemical control of patients, and more therapist supervision than other therapists. Litman (1965) states that obsessive generalized doubt about competency can interfere with a therapist's treatment of other clients. Therapy may take on a more conservative na-

ture due to a fear of the power to hurt others. This conservatism could lead to an unwillingness to engage in genuine therapeutic encounters. Carter (1971) recommends therapy for the therapist in such cases. Also, if the therapist is carrying other high risk suicidal patients either a transfer, or co-therapy should be initiated as two suicides in a short period of time is too much for the best of psychotherapists to endure.

Fears concerning blame, responsibility. Litman (1968) found that therapists expressed the following fears after the death of a client: being investigated and possibly held responsible by the deceased's relatives; being sued, receiving bad publicity, professional embarrassment and possible loss of standing, and an adverse effect on other clients. Most fears center around the question of who is to blame.

Since suicides involve many complex factors, it is difficult for a therapist to determine his role in causality. The difficulty of this task reflects the lack of sophistication of the field of suicide treatment in general (Kahne, 1968). Perr (1965) states in relation to malpractice standards, that a therapist must use skill and judgment comparable to others in his profession and that he may use any one of a number of accepted methods of treatment. He is not responsible for ensuring a good outcome. Statistics prove this to be impossible as suicide has an unpredictable nature.

Rotov (1970) addresses the question of a therapist being responsible for the suicide of a client by both "denying and neutralizing" such a claim. He does so by distinguishing between "necessary" and sufficient" causes of suicide. Suicide is made possible (necessary conditions) by psychosis, depression, social mores, brain disorders, and/or prolonged life stress. Suicide is made more probable (sufficient conditions) by additional factors such as lack of social support, malignant therapy, temporary personal ego weakness, etc. As suggested by Carter (1971), the therapist can never cause suicide, just increase or decrease the probability! Thus, when determining responsibility for suicide, it is best to follow the recommendation of assuming some innocence and considering guilt in terms of degree. However, an objective evaluation requires clear thinking. In an emotional state, damaging blanket judgments are more likely to occur.

The hospital setting. Losing a patient in a hospital setting can be different from private practice (Kahne, 1968). The hospital "machinery" and impersonal procedures often protect the therapist from the sudden demands of family, friends, and officials looking into the patient's death. On the other hand, the suicide is public information in the hospital and the therapist is not allowed a private resolution. There is a sudden necessity to prepare a rational statement about the client's death for evaluation by

one's colleagues. The reports and constant professional gossip usually keep the client's suicide "drowned" in professional jargon. However, the personal feelings of the therapist, other staff, and patients are usually the same as those listed for therapists in private practice--numbness, disbelief, anger, grief, guilt, etc. Kahne (1968) feels that the professional jargon fails to hide these feelings and fears. The therapist's sense of professionalism often crumbles upon hearing of the death.

Resolution and attitude towards future treatment. Successful resolution starts by acknowledging therapist fallibility and limitations in power, by allowing benign self-forgiveness. A sense of professional competence and identity must be maintained by working through the intense personal feelings of grief, guilt, anger, and failure. Finally, the experience should be used in a constructive manner to improve personal and professional sensitivities, judgments, and actions. Litman (1965) and Carter (1971) recommend reviewing the case and presenting it to a group of colleagues with the attitude of learning from the experience. The use of consultation is emphasized as important throughout the entire process. In fact, the wise therapist uses consultation and/or hospitalization during therapy as a preventative to alleviate excessive feelings of guilt and incompetence felt by the therapist in the event of a client's suicide. Litman (1965) found that therapists who had

discussed their patient's cases with a consultant, and therapists who had patients who were hospitalized, had less intense feelings of guilt and incompetence if suicide occurred. Under these circumstances, the therapist was more likely to view the case objectively. They often felt that everything possible had been done for the patient. Also the therapists had personal support and felt that they shared the professional responsibility under the above circumstances.

The suicide of a client invariably gives rise to various emotions such as grief, shame, helplessness, frustration, anxiety, guilt, failure, incompetence, anger, and fears of blame, reprisal, adverse publicity and embarrassment. Considering this, how willing are therapists who have lost a patient (or who are aware of the possible emotional risks) to engage in future treatment with seriously suicidal clients? Litman (1968) found that some therapists considered these risks as an acceptable occupational hazard, while others stated they would avoid working with suicidal clients rather than accept them as a less desirable part of their job.

Reubin's (1973) interview data suggests that psychologists who had lost a client who are "more willing" to treat suicidal clients had used consultation more frequently and had achieved a better resolution of their feelings of failure and loss. (Reubin did not imply causation between these

two events.) His material suggested two factors that may influence the amount of negative affect associated with the death of a client and decisions about future treatment: (1) the treatment prone psychologists' perception that a suicidal crisis is not only serious, but also potentially beneficial and growth-producing in the process of psychotherapy; and (2) the treatment-prone psychologists' better adjustment to failure, internalizing the event less than "neutrally willing to treat psychologists," and experiencing less feelings of incompetence. Litman (1968) also found optimistic therapists who after experiencing failure, said they would welcome other suicidal clients as a special challenge. Their past failure experience would be used to enhance their perception, to become more sensitive as professionals, and to improve their judgments and actions in therapy.

How Undesirable

It may be concluded that, at best, a suicidal client may become a "professional hazard." Considering the many aversive aspects of working with a suicidal client, the therapist's attitude towards the treatment of suicidal clients is not likely to be a positive one.

This is the impression given in the literature and often assumed by researchers. Reubin's (1973) study offers the first look at what factors might influence a therapist

to be motivated to deal with suicide. Still, a field study aimed at assessing how frequently therapists actually do rate the treatment as undesirable, and how basic aspects of the situation contribute to making it so has not been carried out. This study attempts to do just that. In addition, special consideration will be given to Reubin's findings in designing this study.

C H A P T E R I I I

METHODS OF PROCEDURE

This section explains the methodological procedure and rationale followed in this research. The five proceeding content areas are: (1) Hypotheses; (2) Instrumentation; (3) Study Design and Population; and (4) Data Collection.

Hypotheses

This exploratory and descriptive field study surveyed two populations of mental health professionals--psychiatrists and clinical psychologists through the use of a questionnaire. The data obtained were used to explore the validity of two hypotheses. The first hypothesis stated that most therapists find the process of psychotherapy with seriously suicidal clients to be undesirable and prefer not to and/or avoid working with these clients. The second hypothesis stated that significant differences would be found among mental health professionals in association with their ratings of the desirability of treating seriously suicidal clients. The differences explored were among the following areas:

1) Professional Responsibility
2) Professional Ability
3) Difficulties in the Treatment Process

4) Reaction to a Completed Suicide of a Client

5) Professional Experience

6) Personal Attitudes about Suicide

Instrumentation

A questionnaire was designed to provide data for testing the two hypotheses just stated. The questions, largely multiple choice (see Appendix A), contained four different types of items. Some "cafeteria" style multiple choice questions were used to obtain descriptive information about the respondent's experiences and preferences, e.g. items 4 and 8. Many multiple choice items required a single choice from a graded series of response possibilities and thus were scorable. These were used to obtain subjective ratings about the respondent's experiences and feelings, e.g., items 3 and 6. There were some dichotomous choice items requiring a yes-no or similar response. Lastly there were a few open-ended questions.

Although most of the items did not allow the respondent to qualify, clarify, and elaborate his responses to the extent a personal interview approach might allow, there were advantages to the questionnaire approach. Questionnaires offered savings in time and expense. It was possible in a practical manner to obtain a larger sample from a greater geographical area, thus increasing the generalization of the

results. Also a larger sample insured a sufficient frequency of responses to the various categories of responses within items to allow meaningful comparisons. Finally a large sample size helped offset the effects of chance significant findings due to the large number of items and thus, comparisons.

These items were pretested through a pilot study of approximately 20 mental health professionals in the Amherst and Greenfield, Massachusetts, area during the winter of 1975-1976. On the basis of this pretest some items were changed or revised for accuracy, clarity, and content validity. After its final revision, it was prepared for national mailing. The final version contained 48 items. It was expected that the instrument would take 15-30 minutes to complete.

Population

The questionnaires were mailed to a random sample of psychiatrists and psychologists in the United States.

Criteria for selection of the questionnaire subjects. Subjects for this study were chosen from those psychiatrists and clinical psychologists who met the following criteria:

(a) All subjects were male. Women were excluded to limit the scope and maximize the homogeneity of the population.

(b) All subjects had maintained a private, clinic,

or hospital practice for at least two years, and were currently engaged in some type of clinical practice.

(c) All subjects were engaged in a practice which neither excluded nor focused on suicidal clientele. Thus, those working in a field that tended to exclude problems of suicide were excluded (i.e., child psychologists, marriage counselors, child psychiatrists, etc.), as were those who were employed full time at suicide prevention centers or similar agencies which focus on problems of suicide.

(d) All subjects were listed as current members of the American Psychological Association or as Diplomates certified by the American Board of Psychiatry and Neurology.

Obtaining the sample. A table of random numbers was used to select possible subjects from the 1975 American Psychological Association Directory and the 1974-1975 Directory of Medical Specialists, Psychiatry and Neurology (P&N). For example, after determining the range of the number of pages, the number of columns per page, and the number of names per column for the complete listings of those medical doctors listed in the Directory of Medical Specialists, in the section of Psychiatry and Neurology, a table of random numbers was used to generate a list of three past numbers to be used in selecting subjects. A name was chosen, for example, by referring to page 50, column 3, name number 15. If a subject was selected who did not meet the prescribed criteria, the next member listed in the directly was assessed. This procedure, and a similar one for psychologists, was continued until a total of 150 psychiatrists and 150 clinical psycho-

logists had been selected.

Data Collection

Contacting the sample. Each of the 300 subjects was sent a packet containing a letter requesting their participation, a page of introductory comments, a questionnaire, and a stamped, addressed, return envelope. The letter related the nature and importance of the study as well as instructions for completion of the questionnaire (see Appendix B). Subjects were requested to return their answer sheets as soon as possible.

The "introductory comments" addressed possible objections some therapists may have had to filling out the questionnaire. Even if a therapist refused or preferred not to fill out the questionnaire, we was asked to state his reasons on a small blue slip of paper at the bottom of the page and return it in the envelope provided. It was hoped that this would help control for sample bias created by unreturned questionnaires.

The questionnaires were marked to identify psychiatrist respondents from psychologist respondents, while maintaining individual anonymity.

Anticipated subject participation. All questionnaires were mailed simultaneously at the beginning of April, 1976. A postcard was sent to all 300 subjects as a follow-up pro-

cedure three weeks after the mailing date of the questionnaire (see Appendix C). The postcard requested participation by those who had not filled out the questionnaire and thanked those who had filled it out. The total collection period was approximately two months, until the beginning of June, 1976. A 50 percent return rate was anticipated. Reubin (1973), who used similar sampling procedures for 192 subjects, received a 61 percent response rate in an eight-week period and a 62.5 percent response rate by the end of a twelve-week period. He used no follow-up procedure. A minimum return rate of 40% was considered sufficient to analyse the results.

C H A P T E R I V

RESULTS

Overview of the Presentation of the Data

This exploratory and descriptive field study was designed to survey how desirable psychologists and psychiatrists rate the task of treating seriously suicidal individuals and to identify certain personal, professional, and situational factors which might influence these ratings of desirability. This chapter provides a description of the subject participation and presents written description and tables of the statistical results of the data generated by the study variables.

Limits of interpretation. Although the use of a questionnaire has allowed me to make meaningful statistical comparisons and generalize my results to a large population of therapists, there were limits to be considered in the interpretation of my results. My results provide descriptions of the general attitudes therapists hold about the desirability of treatment seriously suicidal clients, the various aspects of the treatment situation, the types and quantity of professional experiences with these clients, and therapists' personal attitudes about suicide. However, the answers to the questions reveal manifest content only. They do not reveal all of the possible factors that could influence these attitudes nor how they influence them. The results suggest

trends that different factors are associated with each other, but do not suggest causation.

Subject Participation

A total of 165 (55%) of the 300 subjects were accounted for by some type of response. Eight of the first class follow-up postcards (see Appendix C) were returned indicating a change of address--unable to forward. Thus, it is assumed that 292 subjects received the questionnaire, 148 psychologists and 144 psychiatrists. Twelve blue slips of rejection of participation (see Appendix B) were received. One hundred and forty-five or 53.8% of the 292 questionnaires assumed to be received by the subjects were mailed back completed. Five of the completed questionnaires were eliminated due to a failure of the respondent to fill out the questionnaire properly, i.e., usually a large number of unanswered questions. Three of the completed responses were received too late to be included in the analysis of the results. Thus 137 questionnaires were analyzed for the results, 82 psychologist and 55 psychiatrist responses.

The written comments on the blue slips and completed questionnaires help explain the 135 questionnaires that were not returned. First of all the use of the follow-up procedure to encourage results and the use of the blue return slip to help account for unreturned questionnaires both ap-

peared to be ineffective procedures. The return rate did not differ from others (e.g., Reubin, 1973) who used neither procedure. A 50%-60% return rate is in this author's understanding quite common and to be expected. The most frequent written comment made reference to time as a reason for non-participation: "My schedule is horrendous"; "You would be amazed how many of these (questionnaires) come to my office"; and "I receive quite a few questionnaires like yours in the mail and wher I see how much time it takes to answer them I usually throw them away. Yours just happened to come along at the right time." Some respondents made reference to the content or style of the questionnaires. This will be discussed in the next section of the paper. In conclusion, I can only assume that the 135 (46.2%) unaccounted for questionnaires were not returned for similar reasons, mainly the imposition on professional time.

General Response to the Questionnaire

The questionnaire, besides requesting the respondent's valuable time, asked the respondent to reflect on his personal feelings and behaviors in a demanding situation, the treatment of seriously suicidal clients. Thus, the nature of this research tended to invade the "sacred ground" of the therapeutic setting, a usually private setting for both client and therapist!

Almost all of the returned questionnaires contained at least minimal comments about the participants' reaction to the questionnaire, item #48 (which solicited any additional comments). A large number of the responses were positive or favorable about the idea of the questionnaire. Many reported it had stimulated them to think or rethink about various issues, e.g., "This has made me think and explore my position with some profit and insight. Most particularly it has made me think of the basis of my motivation to do what work I do with suicide potential patients. . .and it is gratifying to see someone researching this important area with penetrating sensitivity as revealed by the nature of this questionnaire." Others also reiterated their delight in someone investigating the area of the therapists' attitudes and one person suggested that a series of such questions would be useful as part of a training tool for both pre- and post-doctoral training.

However, there was also a smaller but significant number of negative comments about the research. Some made comments on the form and content of the questionnaire, i.e., redundancy, the generality of the questions, the length of the questionnaire, and the limits and restrictiveness of multiple choice questionnaires in accurately reflecting the quality and complexity of their feelings. The most critical comment was, "I believe this to be a sloppy, unscientific, and invalid method of studying suicide or the prevention of

suicide among people."

Others responded to specific questions, often relating aspects of their own treatment approach or personal feelings. Such remarks are mentioned in the analysis of the results for each item.

Finally there were instances of humor such as, "Bewilderment as to why I gain such pleasure in filling out questionnaires like this."

Differences in the Sample Populations

Since each study sample is composed of responses of both psychologists and psychiatrists, the possibility exists that their responses on any one variable differed creating distortion in the interpretation of the results for the combined study samples. To increase the accuracy of interpretation, the responses of psychologists and psychiatrists were compared. For those items generating scorable data, the mean scores for psychiatrists and psychologists were compared for each item. Also the two-way interaction effects between desirability and professional identity on the scores of each item were tested. Six differences between the mean scores were found significant (more than expected by chance). None of the two-way interaction effects were found significant. If the data for any item, either mean scores or cell frequencies, appeared different for psycholo-

gists and psychiatrists, a post hoc analysis was performed to compare the results with desirability ratings separately. Only two such analyses proved significant. These steps were taken to insure that the results of the questionnaire data were uniformly applicable to both professions, unless indicated to be otherwise.

Comparisons of the dependent variables with professional identity of the respondent. The responses on scorable items of the two different therapist populations, psychologists and psychiatrists, were compared with each other to denote six significant differences in their responses (see Table 1):

1) (STRT) Psychiatrists report treating more seriously suicidal clients in the past six months than psychologists ($\alpha = .001$).

2) (CNSLT) Psychologists report greater desirability of consultation when treating a seriously suicidal client ($\alpha = .006$).

3) (RSPRV) Psychiatrists take more responsibility for the prevention of a client's suicide than do psychologists ($\alpha = .001$).

4) (TRAING) Psychiatrists' ratings of the amount of specialized training for the treatment of seriously suicidal clients is higher than psychologists ($\alpha = .004$).

5) (SEXP) Psychiatrists' ratings of the amount of clinical experience with seriously suicidal clients is high-

TABLE 1

Summary of Significant Results from Comparisons of the Dependent Variables (Only Those Capable of Producing Scorable Data) with Item 49 (PSYCH), Professional Identity

Dependent Variables	α
Supplementary:	
Item 5, STRT	.001
Item 29, CNSLT	.006
Area 1:	
Item 10, RSPRV	.001
Area 4:	
Item 32, CMPLS	.001
Area 5:	
Item 35, TRAING	.004
Item 3, SEXP	.004

er than psychologists (α = .004).

6) (CMPLS) More psychiatrists have experienced more completed suicides on the average than psychologists (α = .001).

Tables

Tables 2-48 present selected raw data and the statistical comparisons for all of the items except the three openended ones. The tables for scorable items present sample size (N), mean scores ($\bar{X}$), and standard deviations (SD) for both psychologists and psychiatrists as well as summarizing the statistical comparisons, the degrees of freedom (df), the F values, and the levels of significance for all comparisons. The comparisons for scorable items done by a two-way analysis of variance using F tests were: the ratings of desirability (DES) with each dependent variable; the professional discipline (PSYCH) with each dependent variable; and the two way interaction effects of the ratings of desirability and professional discipline, (DES) x (PSYCH), on each dependent variable. The tables for non-scorable items present sample size (N), frequency distributions, and the statistical comparisons of the ratings of desirability (DES) with each dependent variable, through the use of a χ^2 test of significance.

Table 49 presents a summary of the comparisons of the

ratings of desirability with the dependent variables which were found significant in this research. Table 1 presents a summary of the significant results of the comparisons of scorable dependent variables with professional identity. Significant results are only identified, a detailed discussion and interpretation is presented later.

Table 50 presents the results of the multiple regression analysis.

Analysis of the Independent Variable--Desirability

How desirable a therapist finds the process of psychotherapy with seriously suicidal clients was directly measured by item six. There were five responses to this item ranging from "very desirable" to "extremely undesirable." Table 2 presents the absolute and relative frequencies of response for the respondents. The division of the responses into the three study samples (Undesirable, Acceptable, Desirable) allowed testing of the first experimental hypothesis: Most therapists find the process of psychotherapy with seriously suicidal clients to be undesirable and prefer not to and/or avoid working with these clients. The response frequencies approximate a normal curve centering on Acceptable. Since only 33 (24.1%) respondents rated the therapy process as Undesirable compared to 73 (53.3%) Acceptable and 31 (22.6%) Desirable responses, this hypothesis is not supported. In

TABLE 2

DATA FOR ITEM 6 (DES), THE RATINGS OF THE DESIRABILITY OF PSYCHOTHERAPY WITH SERIOUSLY SUICIDAL CLIENTS

	Absolute Frequency	Relative Frequency (%)
Very Undesirable	7	5.1
Undesirable	26	19.0
Acceptable	73	53.3
Desirable	23	16.8
Very Desirable	8	5.8
	137	100%

Undesirable (U)	33	24.1
Acceptable (A)	73	53.3
Desirable (D)	31	22.6
	137	100%

fact over half of the therapists seem to rate the task as Acceptable.

Supplementary questionnaire items. Supplementary items, not included in the six content areas of independent variables, were added to the questionnaire to provide additional data. Items 5, 7, 8, and 37 provided checks or alternate measures on the ratings of overall desirability on item 6.

Table 3 presents the data for item #5 (STRT), a measure of how many suicidal clients the respondent has treated in the past six months. The mean scores for this item were compared with ratings of desirability by analysis of variance (ANOVA) using an F test of significance. Significance at the .001 level was found suggesting a trend that higher ratings of desirability are associated with higher numbers of suicidal clients treated in the past six months.

Table 4 presented the data for item #7, (ARD) which records the therapist's usual practice of accepting, referring, or refusing seriously suicidal clients for therapy. These nominal data were compared with the ratings of desirability using χ^2 tests of significance. A significance of .0000 suggests a trend that higher ratings of desirability are associated with a greater likelihood of a therapist to accept a client rather than referring the client, or lastly, refusing the client altogether.

Table 5 presents the data for item #8 (LDSRBL), an in-

TABLE 3

Data and Comparisons of Supplementary Item 5 (STRT), the Number of Suicidal Clients Treated in the Past Six Months

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.136 (11) (3.347)	1.582 (22) (1.887)
A	4.867 (30) (2.871)	2.814 (43) (1.865)
D	6.286 (14) (1.949)	4.412 (17) (2.300)
	4.882 (55)	2.815 (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	12.679	.001
(PSYCH)	1	21.874	.001
(DES)x(PSYCH)	2	.120	.999

TABLE 4

DATA AND COMPARISON OF SUPPLEMENTARY ITEM 7 (ARD), THE THERAPIST'S USUAL PRACTICE OF ACCEPTING, REFERRING, OR REFUSING SERIOUSLY SUICIDAL CLIENTS FOR THERAPY

Absolute Frequency Table

	Accept	Refer	Refuse	
U	12	18	3	33
A	59	9	1	69
D	29	2	0	31
	100	29	4	133=N; 4 missing observations.

Comparison	d.f.	X^2	
(DES)	4	36.536	.0000

TABLE 5

DATA AND COMPARISON FOR ITEM 8 (LDSRBL),
THE LEAST DESIRABLE CLINICAL POPULATION

Absolute Frequency Tables

	A) Alcoholics	B) Drug Addicts	C) Psychotics	D) Seriously Suicidal	E) Other	
U	6	11	5	11	0	33
A	23	33	4	2	11	73
D	9	14	5	0	3	31
	38	58	14	13	14	137=N

	ABCE	D	
U	22	11	33
A	71	2	73
D	31	0	31
	124	13	137=N

Comparison	d.f.	X^2	—
(DES)	2	28.9671	.0000

dication of the clinical population the respondent found least desirable. Of all populations drug addicts were the least favored, alcoholics the second least favored. All responses were grouped into two categories: a) seriously suicidal clients; or b) all other choices. These nominal data were then compared with ratings of desirability using a χ^2 test of significance. Significance at the .0000 level was found suggesting a trend that lower ratings of desirability were associated with more frequent choices of seriously suicidal clients as the least desirable client population for the therapist.

Table 6 presents the data for item #37 (WRD), a rating of how rewarding the respondent generally finds psychotherapy with seriously suicidal clients. The responses were scored from 1-4 with a high score indicating the perception of greater rewards. The mean scores were compared with ratings of desirability by ANOVA using F tests. Significance was found at the .001 level suggesting a trend that higher ratings of desirability are related to the perception of greater rewards in the process of therapy.

Summary of the results of supplementary items 5, 7, 8, & 37. These items were included to provide checks or alternative measures on the ratings of desirability for item #6. The data for all four variables varied significantly in the expected directions as a function of the ratings of desirability of treating seriously suicidal clients. These find-

TABLE 6

Data and Comparisons for Item 37 (RWRD), the Degree of Reward from Therapy with Seriously Suicidal Clients

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.636 (11) (.674)	2.250 (20) (.716)
A	2.786 (28) (.568)	2.881 (42) (.395)
D	3.214 (14) (.579)	3.188 (16) (.655)
	2.878 (53)	2.773 (78)

N = 131; six missing cases

Comparisons	d.f.	F	α
(DES)	2	15.546	.001
(PSYCH)	1	.178	.999
(DES)x(PSYCH)	2	1.803	.167

ings support the propositions that 1) item #6 is capable of distinguishing among the three different levels of desirability of the treatment of seriously suicidal clients, and 2) the criteria used to generate the three sample populations for this study are operationally valid. Thus, justification is provided for the comparative analyses of the ratings of desirability with the dependent variables which allows testing of the second hypothesis.

Introduction to Analysis of the Dependent Variables

The second purpose of this research study was to identify aspects of the treatment situation and differences in the personal attitudes toward suicide and in professional experiences that affected ratings of desirability. These factors were to be explored among six different content areas; the items of the six areas became the dependent variables. The second experimental hypothesis predicted that differences would be found among mental health professionals as a function of their ratings of the desirability of treating seriously suicidal clients.

The second hypothesis was tested by comparing the responses to items among the three study samples, generated by dividing all responses to item 6 into the categories of Desirable, Acceptable, and Undesirable. Depending on the ability to score the items representing the dependent vari-

ables, either ANOVA using F tests of significance or chi-squared tests of significance were utilized to compare the differences of responses among the three study samples. An alpha level of .01 was set for all comparisons. All computations were done by computer.

Analysis of Area 1--Professional Responsibility

Area One contained three items designed to elicit opinions and information concerning the professional responsibility involved in treating seriously suicidal clients. Table 7 presents the data for item #9 (TRGHT), a measure of how much responsibility a therapist takes for deciding if a seriously suicidal client has a moral right to suicide. This item was scored from 1 to 4, higher scores indicating more acceptance of responsibility. The mean scores were compared with the ratings of desirability by ANOVA using F tests of significance. The differences between the means were not found to be significant. A post hoc analysis was performed to see if the higher mean score for Desirable psychiatrists differed significantly from the lower mean scores for Acceptable and Undesirable psychiatrists. Again, significance was not found.

Table 8 presents the data for item #10 (RSPRV), the responsibility for the prevention of suicide. This item was scored from 1 to 4, higher scores indicating more responsi-

TABLE 7

Data and Comparisons for Item 9 (TRGHT), the Responsibility for Deciding on a Client's Moral Right to Suicide

Desirability	Psychiatrists	Psychologists
	$\bar{X}$ (N) (SD)	$\bar{X}$ (N) (SD)
U	2.273 (11) (1.104)	1.800 (20) (.768)
A	1.963 (27) (1.192)	1.810 (42) (.671)
D	2.758 (12) (.965)	1.941 (17) (1.029)
	2.222 (50)	1.835 (79)

N = 129; eight missing cases

Comparisons	d.f.	F	α
(DES)	2	1.874	.156
(PSYCH)	1	5.078	.024
(DES)x(PSYCH)	2	1.275	.282

TABLE 8

Data and Comparisons for Item 10 (RSPRV),
Responsibility for the Prevention of a Client's Suicide

Desirability	Psychiatrists	Psychologists
	$\bar{X}$ (N) (SD)	$\bar{X}$ (N) (SD)
U	3.000 (11) (.775)	2.273 (22) (.703)
A	2.467 (30) (.819)	2.116 (43) (.586)
D	3.000 (14) (.679)	2.647 (17) (.862)
	2.891 (55)	2.268 (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	6.256	.003
(PSYCH)	1	11.921	.001
(DES)x(PSYCH)	2	.774	.999

bility. The mean scores were compared with ratings of desirability by ANOVA using an F test of significance. Significance was found at the .003 level suggesting, upon examination of the mean scores, a trend that Acceptable therapists accept the less responsibility than Undesirable therapists, while Desirable therapists accept the most. However, examination of the means for the three study groups of desirability for psychologists and psychiatrists individually shows an even more complex picture. The mean scores for Desirable and Undesirable psychiatrists are equal and the difference between the means for Undesirable and Acceptable psychologists is small. Statistical significance was due to the difference between the means of the combined scores of psychologists and psychiatrists. It is surprising the interaction effect ($\alpha = .999$) between ratings of desirability and professional identity is not significant here.

Table 9 presents the data for item #11 (FRSP), the greatest influence on attitudes of responsibility in the treatment of seriously suicidal clients. Frequency counts were used to generate data to compare the responses with desirability ratings using a χ^2 test of significance. Significance was not found. Professional role, personal philosophy, and professional experience were equally chosen by respondents. The choices of professional role and professional experience probably overlap considerably. The combined response to both of these choices accounts for 60.85%

TABLE 9

DATA AND COMPARISON FOR ITEM 11 (FRSP), THE FACTOR THAT MOST INFLUENCES ATTITUDE TOWARDS RESPONSIBILITY

Absolute Frequency Table

	Professional Role	Personal Philosophy	Professional Experience	Other	
U	9	13	9	2	33
A	18	24	24	7	73
D	11	6	12	2	31
	38	43	45	11	137=N

Comparison	d.f.	χ^2	α
(DES)	6	4.1916	.6508

of the total response, which leads to the conclusion that professional related experiences are the most important in influencing attitudes of responsibility.

Analysis of Area 2--Professional Ability

Table 10 presents the data for item #12 (ABLTY), the respondents' self-rating of ability in terms of skill and knowledge to effectively manage and treat a client who is seriously suicidal. The responses were scored from 1 to 4, a high score indicating a high rating of ability. The mean scores were compared with desirability ratings by ANOVA using an F test of significance. Significance was found at the .001 level suggesting a trend that higher ratings of ability are associated with higher ratings of desirability.

Table 11 presents the data for item #13 (FABLTY), the factor the therapist felt contributed the most to his ratings of ability in item #12. This nominal data was compared with the ratings of desirability using a χ^2 test of significance. Significance was not found. Examination of the raw data shows that more than half of the respondents (58.8%) feel that the amount of training or professional experience they have with the task influences their ratings of ability the most! Personal characteristics as a therapist was specified by 29.4% of the respondents as most influential.

TABLE 10

Data and Comparisons for Item 12 (ABLTY), Ability to Treat Seriously Suicidal Clients

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.000 (11) (.632)	2.619 (21) (.669)
A	3.233 (30) (.568)	3.023 (43) (.636)
D	3.500 (14) (.519)	3.529 (17) (.624)
	3.244 (55)	3.057 (81)

N = 136; one missing case

Comparisons	d.f.	F	α
(DES)	2	11.555	.001
(PSYCH)	1	3.166	.074
(DES)x(PSYCH)	2	.848	.999

TABLE 11

DATA AND COMPARISON FOR ITEM 13 (FABLTY), THE FACTOR THAT MOST INFLUENCES RATINGS OF ABILITY

Absolute Frequency Table

	Amount of Training or Experience	Ease or Difficulty of Task	Personal Characteristics as a Therapist	Other	
U	21	3	8	0	32
A	38	2	24	9	73
D	21	0	8	2	31
	80	5	40	11	136=N

1 missing observation

Comparison	d.f.	χ^2	α
(DES)	6	10.3404	.1110

Analysis of Area 3--Difficulties in the Treatment Process

Area 3 investigates difficulties of the treatment process of seriously suicidal clients that could make it an undesirable task (a total of 13 items, Tables 12-24).

Table 12 presents the data for item #14 (DIFF), a general rating of the difficulty of treating a seriously suicidal client apart from the ability rating. This item was scored 1 to 4, higher scores indicating greater difficulty. The mean scores were compared with the ratings of desirability by ANOVA using an F test of significance. Significance was found at the .005 level suggesting a trend that higher ratings of desirability are associated with lower ratings of difficulty.

Table 13 presents the data for item #15 (CRSTRS), the therapist's self-rating of the anxiety a suicidal crisis in therapy elicits in him. This item was scored from 1 to 4, higher scores indicating greater anxiety. The mean scores were compared with the ratings of desirability by ANOVA using an F test of significance. Significance was not found.

Table 14 presents the data for item #16 (DCRSTRS), the therapists' difficulty in dealing with their own anxiety elicited by a suicidal crisis of a client. This item was scored from 1 to 4, higher scores indicating greater difficulty. Mean scores for this item were compared with ratings of desirability after eliminating those in each of the three

TABLE 12

Data and Comparisons for Item 14 (DIFF), the Difficulty of Managing and Treating a Seriously Suicidal Client

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.545 (11) (.522)	3.773 (22) (.429)
A	3.233 (30) (.774)	3.558 (43) (.502)
D	3.143 (14) (.663)	3.118 (17) (.928)
	3.307 (55)	3.483 (82)

N = 137

Comparisons	d.f.	F	α
(DES)	2	5.652	.005
(PSYCH)	1	3.859	.049
(DES)x(PSYCH)	2	.795	.999

TABLE 13

Data and Comparisons for Item 15 (CRSTRS), Therapist Anxiety Associated with a Client's Suicidal Crisis

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.182 (11) (.603)	2.952 (21) (.740)
A	2.800 (30) (.610)	2.976 (42) (.604)
D	3.000 (14) (.784)	2.824 (17) (.883)
	2.994 (55)	2.917 (80)

N = 135; two missing observations

Comparisons	d.f.	F	α
(DES)	2	.423	.999
(PSYCH)	1	.000	.999
(DES)x(PSYCH)	2	1.232	.295

TABLE 14

Data and Comparisons for Item 16 (DCRSTRS), the Difficulty of Dealing with Anxiety Associated with a Client's Suicidal Crisis

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.700 (10) (.675)	2.706 (17) (.588)
A	2.478 (23) (.511)	2.529 (34) (.507)
D	2.600 (10) (.843)	2.615 (13) (.506)
	2.593 (43)	2.616 (64)

N = 107; conditional, no missing cases

Comparisons	d.f.	F	α
(DES)	2	1.084	.343
(PSYCH)	1	.081	.999
(DES)x(PSYCH)	2	.017	.999

study samples, (Undesirable, Acceptable, Desirable) who chose answers (c) or (d) for item #15 (see items 15 and 16 in Appendix A). ANOVA using an F test of significance did not yield significant results.

Table 15 presents the data for item #17 (SGCRS), the perceived significance of a client's suicidal crisis. This nominal data was compared with the ratings of desirability using a χ^2 test of significance. Although the data did not produce significance, a post hoc analysis did produce significant results. The three sample populations were divided by professional identity producing three sample populations of desirability for psychologists and three separate sample populations for psychiatrists. Chi-squared tests produced significance for psychologists ($\alpha = .005$), but not for psychiatrists ($\alpha = .508$). The data thus indicates a trend that the more desirable a psychologist (but not a psychiatrist) rates psychotherapy with seriously suicidal clients, the more likely he is to perceive a suicidal crisis as a positive and important part of the therapeutic process.

Table 16 presents the data for item #18 (TIME), a general rating of the extra commitment of time and effort involved in the treatment of seriously suicidal individuals. The item was scored 1 to 4, higher scores indicating greater effort. Mean scores were compared with the desirability ratings by ANOVA using an F test of significance. The data did not produce significant results.

TABLE 15

DATA AND COMPARISONS FOR ITEM 17 (SGCRS), THE PERCEIVED SIGNIFICANCE OF A CLIENT'S SUICIDAL CRISIS

	Psychologists			
	a) Important	b) Secondary	c) Interruption	
U	5	4	11	20
A	17	15	8	40
D	11	4	1	16
	33	23	20	76=N

	Psychiatrists			
	a) Important	b) Secondary	c) Interruption	
U	4	2	3	9
A	11	5	10	26
D	3	6	5	14
	18	13	18	49=N

Comparisons	d.f.	X^2	—
Total (DES)	4	6.2298	.1826
Psychologists (DES)	4	14.7771	.0052
Psychiatrists (DES)	4	3.3035	.5084

TABLE 16

Data and Comparisons for Item 18 (TIME), the Extra Effort and Time Involved in Treatment

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.636 (11) (.674)	3.286 (21) (.845)
A	3.367 (30) (.615)	3.262 (42) (.627)
D	3.571 (14) (.514)	3.000 (17) (.935)
	3.525 (55)	3.183. (80)

N = 135; two missing cases

Comparisons	d.f.	F	α
(DES)	2	.538	.999
(PSYCH)	1	4.815	.028
(DES)x(PSYCH)	2	1.245	.291

Table 17 presents the data for item #19 (FTIME), the therapists' feelings about an extra commitment of time and energy. This item was scored from 1 to 4, higher scores indicating more negative feelings. Mean scores were compared with the ratings of desirability after eliminating from the three study samples (Undesirable, Acceptable, Desirable) those who chose answers (c) or (d) for item #18 (see Appendix A, items #18 and #19). ANOVA using an F test of significance produced significance at the .002 level suggesting a trend that the more undesirable a respondent rates psychotherapy with seriously suicidal clients the more an extra commitment of time and energy is experienced as an inconvenience or burden.

Table 18 presents the data for item #20 (DIFCHAR), the difficulty of dealing with the character and/or life situation of seriously suicidal clients. This item was scored from 1 to 4, higher scores indicating greater difficulty. Mean scores were compared with ratings of desirability by ANOVA using an F test of significance. The data did not produce significance.

Table 19 presents the data for item #21 (RISK), the difficulty of estimating suicidal risk. This item was scored from 1 to 4, higher scores indicating greater difficulty. Mean scores were compared with the ratings of desirability by ANOVA using an F test of significance. Significance was found at the .001 level suggesting a trend

TABLE 17

Data and Comparisons for Item 19 (FTIME), Feelings Associated with the Extra Effort in Treatment

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.182 (11) (.874)	3.400 (20) (.681)
A	3.067 (30) (.785)	3.048 (42) (.582)
D	2.643 (14) (.745)	2.647 (17) (.786)
	2.964 (55)	3.032 (79)

N = 134; conditional

Comparisons	d.f.	F	α
(DES)	2	7.035	.002
(PSYCH)	1	.094	.999
(DES)x(PSYCH)	2	.290	.999

TABLE 18

Data and Comparisons for Item 20 (DFCHAR), the Difficulty of Dealing with the Suicidal Character

Desirability	Psychiatrists	Psychologists
	$\bar{X}$ (N) (SD)	$\bar{X}$ (N) (SD)
U	2.455 (11) (.688)	2.429 (21) (.746)
A	2.633 (30) (.850)	2.381 (42) (.697)
D	2.500 (14) (.760)	2.000 (17) (.935)
	2.529 (55)	2.270 (80)

N = 135; two missing observations

Comparisons	d.f.	F	α
(DES)	2	1.348	.262
(PSYCH)	1	3.628	.056
(DES)x(PSYCH)	2	.691	.999

TABLE 19

Data and Comparisons for Item 21 (RISK), the Difficulty of Estimating a Client's Potential as a Suicidal Risk

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.909 (11) (.701)	3.227 (22) (.813)
A	2.600 (30) (.770)	2.690 (42) (.604)
D	2.571 (14) (.756)	2.294 (17) (.920)
	2.693 (55)	2.737 (81)

N = 136; one missing case

Comparisons	d.f.	F	α
(DES)	2	7.424	.001
(PSYCH)	1	.178	.999
(DES)x(PSYCH)	2	1.245	.291

that the more difficulty a therapist has in estimating suicidal risk, the more undesirable he finds psychotherapy with seriously suicidal clients.

Table 20 presents the data for item #22 (DISHOSP), the difficulty of making restrictive decisions for suicide prevention. This item was scored from 1 to 4, higher scores indicating greater difficulty. Mean scores were compared with ratings of desirability by ANOVA using an F test of significance. The data did not produce significant results. Nothing the large difference between the sample means for psychologists, a post hoc analysis using t tests was performed. The same mean for Undesirable psychiatrists was compared with the sample mean for Desirable psychiatrists; the same comparison was done for psychologists. Significance at the .002 level was found for psychologists suggesting a trend that psychologists who rated psychotherapy with seriously suicidal clients as desirable found restrictive decisions less difficult to make than those who rated it as undesirable. This was not indicated for psychiatrists (α = .525)!

Table 21 presents the data for item 23 (DIFPREV), the difficulty of preventing suicide. This item was scored from 1 to 4, higher scores indicating greater difficulty. Mean scores were compared with the ratings of desirability by ANOVA using an F test of significance. Significance was found at the .017 level, not quite significant by the .01

TABLE 20

Data and Comparisons for Item 22 (DIFHOSP), the Difficulty of Making Decisions about Restrictive Measures to Prevent Suicide

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.000 (11) (.894)	2.273 (22) (.935)
A	1.867 (30) (1.008)	2.023 (43) (.672)
D	1.786 (14) (.802)	1.471 (17) (.717)
	1.884 (55)	1.922 (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	3.646	.028
(PSYCH)	1	.242	.999
(DES)x(PSYCH)	2	1.127	.327

Post hoc Comparisons	d.f.	T.	α
Psychiatrists (U x D)	131	.637	.525
Psychologists (U x D)	131	2.974	.004

TABLE 21

Data and Comparisons for Item 23 (DIFPRV), the Difficulty of Preventing the Suicide of a Client

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.818 (11) (.603)	3.045 (22) (1.046)
A	2.533 (30) (1.008)	2.857 (42) (.783)
D	2.357 (14) (.745)	2.294 (17) (.772)
	2.569 (55)	2.732. (81)

N = 136; one missing case

Comparisons	d.f.	F	α
(DES)	2	4.196	.017
(PSYCH)	1	1.915	.165
(DES)x(PSYCH)	2	.532	.999

criteria, but pointing towards a trend that the more undesirable a therapist rated psychotherapy with seriously suicidal clients, the less difficult he finds it to prevent the suicide of a client.

Table 22 presents the data for item #24 (CT), the belief that therapist behavior can lead to the suicide of a client. Table 23 presents the data for item #25 (WCT), the therapist's personal concern about making a mistake that would lead to a client's suicide. Table 24 presents the data for item #28 (BLAME), the vulnerability to blame a therapist would feel if a client committed suicide. These three items were scored 1 to 4, higher scores indicating stronger belief (item #24), more concern (item #25), and greater vulnerability (item #28). Mean scores were compared with the ratings of desirability by ANOVA using F tests of significance. The data for all three items failed to produce significance.

Analysis of Area 4--
Reaction to the Completed Suicide of a Client

The completed suicide of a client in therapy is probably the most unwanted and traumatic event a therapist could encounter in his professional career. The items of Area 4 pertain to such an event to determine if the event of suicide has an effect on desirability ratings.

TABLE 22

Data and Comparisons for Item 24 (CT), the Belief that a Mistake by the Therapist Could Lead to the Suicide of a Client

Desirability	Psychiatrists	Psychologists
	$\bar{X}$ (N) (SD)	$\bar{X}$ (N) (SD)
U	2.455 (11) (.688)	2.775 (22) (.685)
A	2.933 (30) (.691)	2.814 (43) (.546)
D	2.857 (14) (.864)	2.529 (17) (.624)
	2.748 (55)	2.705 (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	1.412	.246
(PSYCH)	1	.370	.999
(DES)x(PSYCH)	2	1.908	.150

TABLE 23

Data and Comparisons for Item 25 (WCT), Concern as a Therapist that a Mistake or Action Could Lead to the Suicide of a Client

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.091 (11) (.944)	3.182 (22) (.795)
A	3.167 (30) (.648)	3.093 (43) (.648)
D	3.000 (14) (.877)	3.000 (16) (.730)
	3.086 (55)	3.092 (81)

N = 136; one missing case

Comparisons	d.f.	F	∝
(DES)	2	.404	.999
(PSYCH)	1	.023	.999
(DES)x(PSYCH)	2	.134	.999

TABLE 24

Data and Comparisons for Item 28 (BLAME), Vulnerability to Public or Professional Blame as a Therapist of a Client Who Committed Suicide

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.636 (11) (.809)	2.571 (21) (.811)
A	2.300 (30) (.750)	2.326 (43) (.865)
D	2.286 (14) (.825)	2.235 (17) (.970)
	2.407 (55)	2.377 (81)

N = 136; one missing case

Comparisons	d.f.	F	α
(DES)	2	1.575	.209
(PSYCH)	1	.007	.999
(DES)x(PSYCH)	2	.040	.999

Tables 25 and 26 present the data for item #25 (STRMA), the amount of emotional stress a therapist feels is precipitated due to the suicide of a client and item #26 (DSTRMA), the difficulty the therapist has in dealing with this emotional stress. Both items were scored from 1 to 4 with higher scores indicating higher amounts of stress and greater difficulty in dealing with it. Table 27 presents the data for item #32 (CMPLS), the frequency of completed suicides for a therapist. Table 28 presents the data for item #30 (SCNSLT), the use of consultation to help deal with the feelings associated with the loss of a client by suicide. This item was scored from 1 to 3, a lower score indicating less use of consultation. For all four of these items, mean scores were compared with the ratings of desirability by ANOVA using F tests of significance. The data for all four items failed to produce significance.

Table 29 presents the data for item #33 (PLCMPLS), the clinical setting in which the therapist had been treating patients who committed suicide. Table 30 presents the data for item #34 (SEFFECT), the effect a completed suicide(s) had on the respondent's attitude toward the treatment of seriously suicidal clients. Both items consisted of four unscorable categories of response. Frequency counts were used to generate data for comparing the responses of each item with the ratings of desirability using chi-squared tests of significance. The three study samples (Undesir-

TABLE 25

Data and Comparisons for Item 26 (STRMA), the Emotional Stress Precipitated by the Suicide of a Client

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	3.364 (11) (.924)	3.273 (22) (.631)
A	3.333 (30) (.661)	3.442 (43) (.629)
D	3.429 (14) (.646)	3.375 (16) (.806)
	3.375 (55)	3.363 (81)

N = 136; one missing case

Comparisons	d.f.	F	α
(DES)	2	.250	.999
(PSYCH)	1	.047	.999
(DES)x(PSYCH)	2	.284	.999

TABLE 26

Data and Comparisons for Item 27 (DSTRMA), the Difficulty of Dealing with the Emotional Stress Due to a Client's Suicide

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.636 (11) (1.027)	2.476 (21) (.873)
A	2.600 (30) (.894)	2.581 (43) (.663)
D	2.511 (14) (.646)	2.625 (16) (.957)
	2.602 (55)	2.561 (80)

N = 135; two missing cases

Comparisons	d.f.	F	α
(DES)	2	.062	.999
(PSYCH)	1	.054	.999
(DES)x(PSYCH)	2	.131	.999

TABLE 27

Data and Comparisons for Item 32 (CMPLS), the Number of Completed Suicides a Therapist Has Experienced

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	.659 (22)	2.045 (11)
A	.825 (43)	1.683 (30)
D	1.294 (17)	2.071 (14)
	.969 (82)	1.854 (55)

N = 137

Comparisons	d.f.	F	α
(DES)	2	1.338	.265
(PSYCH)	1	18.729	.001
(DES)x(PSYCH)	2	.554	.999

TABLE 28

DATA AND COMPARISON FOR ITEM 33 (PLCMPLS), THE CLINICAL SETTING IN WHICH A THERAPIST EXPERIENCED THE SUICIDAL DEATH OF A CLIENT

Absolute Frequency Table

	Private Practice	Outpatient Clinic	Inpatient Setting	Other	
U	6	8	2	0	16
A	18	8	7	8	41
D	12	4	2	3	21
	36	20	11	11	78=N (conditional)

Comparison	d.f.	χ^2	α
(DES)	6	9.2189	.1616

TABLE 29

Data and Comparisons for Item 30 (SCNSLT), the Use of Consultation to Deal with a Client's Completed Suicide

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	1.625 (8) (.518)	1.714 (7) (.951)
A	1.500 (22) (.512)	2.000 (18) (.907)
D	1.545 (11) (.688)	1.778 (9) (.667)
	1.536 (41)	1.778 (34)

N = 75; conditional, three missing cases

Comparisons	d.f.	F	α
(DES)	2	.092	.999
(PSYCH)	1	4.380	.038
(DES)x(PSYCH)	2	.536	.999

TABLE 30

DATA AND COMPARISON FOR ITEM 34 (SEFFECT), SIGNIFICANT EFFECT OF A CLIENT'S COMPLETED SUICIDE

Absolute Frequency Table

	Positive Effect	Negative Effect	No Effect	Other	
U	8	2	6	0	16
A	21	6	12	2	41
D	9	0	9	2	20
	38	8	27	4	77=N (conditional)

Comparison	d.f.	χ^2	α
(DES)	6	5.6755	.4605

able, Acceptable, Desirable) in these cases included only those who have lost at least one client by suicide. Significance was not found for the data on either item.

Analysis of Area 5--Professional Experience

Area 5 contains nine items covering different aspects of the quantity and quality of a therapist's experiences as a professional that might influence his attitudes toward treating seriously suicidal clients.

Table 31 presents the data for item #49, which did not appear on the questionnaire, but pertained to the therapist's professional identity as a psychiatrist or a clinical psychologists as indicated by coding of the questionnaire. The frequency of each profession among the three study samples of ratings of desirability (Undesirable, Acceptable, Desirable) were compared using a chi-squared test of significance. The data did not produce significance.

Table 32 presents the data for item #1 (YREXP), the years of professional experience the respondent has had in clinical practice. Table 33 presents the data for item #35 (TRAING), the amount of specialized or specific training a therapist has had for dealing with seriously suicidal clients. Table 34 presents the data for item #3 (SEXP), the amount of clinical experience a therapist has had with seriously suicidal clients. Items #35 and #3 were scored from

TABLE 31

DATA AND COMPARISON FOR ITEM 49 (PSYCH),
PROFESSIONAL IDENTITY

Absolute Frequency Table

Desirability	Psychologists	Psychiatrists	
U	22	11	33
A	43	30	73
D	17	14	31
	82	55	137=N

Comparison	d.f.	X^2	α
(DES)	2	.9893	.6098

TABLE 32

Data and Comparisons for Item 1 (YREXP), the Years of Professional Experience of a Therapist

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	15.455 (11) (1.214)	14.841 (22) (2.998)
A	14.367 (30) (3.034)	12.523 (43) (4.348)
D	13.034 (14) (2.766)	12.971 (17) (4.332)
	14.285 (55)	13.445, (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	3.510	.032
(PSYCH)	1	4.186	.040
(DES)x(PSYCH)	2	.488	.999

TABLE 33

Data and Comparisons for Item 28 (TRAING), the Amount of Specialized or Specific Training a Therapist Has Had for Dealing with Seriously Suicidal Clients

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.636 (11) (.924)	2.273 (22) (.883)
A	3.033 (30) (.850)	2.581 (43) (.763)
D	3.500 (14) (.760)	3.059 (17) (.827)
	3.436 (55)	2.597 (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	7.824	.001
(PSYCH)	1	8.900	.004
(DES)x(PSYCH)	2	.031	.999

TABLE 34

Data and Comparisons for Item 3 (SEXP), the Amount of Clinical Experience with Seriously Suicidal Clients

Desirability	Psychiatrists	Psychologists
	$\bar{X}$ (N) (SD)	$\bar{X}$ (N) (SD)
U	3.182 (11) (.751)	2.636 (22) (.727)
A	3.100 (30) (.607)	2.884 (43) (.662)
D	3.643 (14) (.633)	3.235 (17) (.437)
	3.254 (55)	2.890 (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	6.917	.002
(PSYCH)	1	8.882	.004
(DES)x(PSYCH)	2	.743	.999

1 to 4, higher scores indicating more training and experience. The mean scores for all three of these items were compared with the ratings of desirability by ANOVA using F tests of significance. The data for item #1 (YREXP) failed to produce significance. Significance was found at the .001 level for item #35 (TRAING), suggesting a trend that higher ratings of desirability are associated with greater amounts of specialized training for dealing with seriously suicidal clients. Also, significance was found at the .002 level for item #3 (SEXP) suggesting a trend that higher ratings of desirability are associated with more clinical experience with seriously suicidal individuals.

Table 35 presents the data for item #35 (PREPARE), which recorded what type of experience a therapist thinks would best prepare him to deal professionally with seriously suicidal clients. Frequency counts for the different categories were used to generate data to compare the responses for this item among the three study samples of the ratings of desirability (Undesirable, Acceptable, Desirable) using chi-squared tests of significance. Although the data did not produce significance, professional training was chosen most often as the most important factor to prepare the therapist for psychotherapy with seriously suicidal clients.

Table 36 presents the data for item #2 (PLCEXP), the clinical setting in which the therapist had most of his general clinical experience. Table 37 presents the data for

TABLE 35

DATA AND COMPARISON FOR ITEM 36 (PREPARE), THE BEST PREPARATION FOR DEALING WITH SUICIDAL CLIENTS

Absolute Frequency Table

	Personal Experience	Professional Experience	Personal Philosophy	Professional Training	Personal Mental Health	Other	
U	0	5	7	15	2	4	33
A	2	15	19	20	5	11	72
D	1	7	3	16	1	3	31
	3	27	29	51	8	18	136=N

1 missing case

Comparison	d.f.	X^2	—
(DES)	10	9.42197	.4926

TABLE 36

DATA AND COMPARISON FOR ITEM 2 (PLCEXP), PLACE OF MOST CLINICAL EXPERIENCE

Absolute Frequency Table

	Private Practice	Inpatient Setting	Outpatient Clinic	Other	
U	23	4	4	2	33
A	40	9	15	9	73
D	11	8	2	10	31
	74	21	21	21	137=N

Comparison	d.f.	χ^2	α
(DES)	6	17.5384	.0075

TABLE 37

DATA AND COMPARISON FOR ITEM 4 (SPLCEXP), PLACE OF MOST CLINICAL EXPERIENCE WITH SERIOUSLY SUICIDAL CLIENTS

Absolute Frequency Table

	Private Practice	Inpatient Setting	Outpatient Clinic	Other	
U	14	10	3	6	33
A	26	18	16	12	72
D	7	10	2	12	31
	47	38	21	31	136=N

1 missing case

Comparison	d.f.	χ^2	α
(DES)	6	12.1220	.0593

item #4 (SPLCEXP), the clinical setting in which the therapist had the most experience with seriously suicidal clients. Frequency counts of the different categories of responses were compiled and the results for each item were compared with the three study samples of the ratings of desirability using chi-squared tests of significance. Significance was found for item #2 (PLCEXP) at the .0075 level suggesting a trend that lower ratings of desirability are associated with therapists who are more likely to have had most of their experience in private practice.

A look at the raw data aids in interpreting this finding. The percentage of respondents, per level of desirability, that indicated they had most of their clinical experience in private practice decreases from 69.6% for Undesirable to 54.7% for Acceptable to 35.5% for Desirable. The percentage of those choosing other settings increases in the same direction from Undesirable to Desirable. The data for item #4 (SPLEXP) failed to produce significance.

Analysis of Area 6--Personal Attitudes about Suicide

Area 6 contains eight items designed to explore the respondents' personal attitudes about suicide.

Table 38 presents the data for item #40 (CNTMPLT), the serious contemplation of suicide. Table 39 presents the data for item #41 (ATTEMPT), the occurence of an actual sui-

TABLE 38

DATA AND COMPARISON FOR ITEM 40 (CNTMPLT), SERIOUS CONTEMPLATION OF SUICIDE BY A THERAPIST

Absolute Frequency Table

Desirability	Yes	No	
U	4	29	33
A	17	56	73
D	7	24	31
	28	109	137=N

Comparisen	d.f.	X^2	α
(DES)	2	1.8558	.3954

TABLE 39

DATA AND COMPARISON FOR ITEM 41 (ATTEMPT),
ACTUAL THERAPIST ATTEMPT AT SUICIDE

Absolute Frequency Table

Desirability	Yes	No	
U	1	32	33
A	0	73	73
D	1	30	31
	2	135	137=N

Comparisen	d.f.	X^2	α
(DES)	2	2.3193	.3136

cide attempt. Both questions can be answered only yes or no. Table 40 presents the data for item #42 (PRBLTY), the therapists' estimated lifetime probability of committing suicide. There are only two response possibilities, "possible" and "doubtful." Table 41 presents the data for item #43 (DIE), the occurrence of a wish to die. The five response categories were scored yes or no. The frequency counts of the data for these four items were compared with the ratings of desirability (Undesirable, Acceptable, Desirable) using χ^2 tests for significance. All comparisons failed to produce significance. The data for items 40-43 reveal that most of the respondents have never seriously contemplated suicide (79.56%), most doubted they would ever do it under any circumstances (65%), most have never really wanted to die for any reason (63.5%), and most have never attempted suicide (97.45%). The existence of suicidal behaviors is not only absent in most of the respondents' answers, but appears to be unrelated to their professional attitudes about the desirability of treating seriously suicidal clients.

Table 42 presents the data for item #44 (SOLUTION), the endorsement of suicide as a solution to life's problems. Table 43 presents the data for item #46 (PRGHT), the endorsement of a person's moral right to suicide. These items were scored from 1 to 4, higher scores indicating more endorsement. The mean scores for each item were compared with the

TABLE 40

DATA AND COMPARISON FOR ITEM 42 (PRBLTY), THE THERAPIST'S LIFETIME PROBABILITY OF COMMITTING SUICIDE

Absolute Frequency Table

Desirability	Possible	Doubtful	
U	12	20	32
A	24	48	72
D	11	20	31
	47	88	135=N

2 missing cases

Comparison	d.f.	X^2	α
(DES)	2	.17742	.9151

TABLE 41

DATA AND COMPARISON FOR ITEM 43 (DIE),
EXPERIENCE OF A WISH TO DIE

Absolute Frequency Table

Desirability	Yes	No	
U	9	24	33
A	22	41	73
D	9	22	31
	50	87	137=N

Comparisen	d.f.	X^2	α
(DES)	2	3.6531	.1610

TABLE 42

Data and Comparisons for Item 44 (SOLUTION), Suicide as a Viable Philosophic Solution to Life's Problems

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.818 (11) (.874)	2.857 (21) (.964)
A	3.033 (30) (.718)	2.767 (43) (.782)
D	3.214 (14) (.579)	2.765 (17) (.752)
	3.022 (55)	2.796 (81)

N = 136; one missing case

Comparisons	d.f.	F	α
(DES)	2	.149	.999
(PSYCH)	1	3.079	.078
(DES)x(PSYCH)	2	.738	.999

TABLE 43

Data and Comparisons for Item 46 (PRGHT), a Person's Moral Right to Suicide

Desirability	Psychiatrists $\bar{X}$ (N) (SD)	Psychologists $\bar{X}$ (N) (SD)
U	2.100 (10) (.738)	2.350 (20) (1.089)
A	2.296 (27) (.912)	2.286 (42) (.835)
D	1.833 (12) (.389)	2.563 (16) (.964)
	2.1426 (49)	2.359 (78)

N = 127; 10 missing cases

Comparisons	d.f.	F	α
(DES)	2	.024	.999
(PSYCH)	1	1.826	.176
(DES)x(PSYCH)	2	1.724	.181

ratings of desirability (Desirable, Acceptable, Undesirable) by ANOVA using F tests for significance. The data for both items did not produce significance.

Table 44 presents the data for item #45 (CNFLCT), the existence of a conflict between personal and professional attitudes towards suicide. This item was answered either yes or no. The data were compared with the ratings of desirability by a χ^2 test of significance. Significance was found at the .0027 level. Examination of the data shows that those who rated therapy with seriously suicidal clients to be Acceptable more frequently reported a conflict than those who rated it Undesirable or Desirable! Of the 28 respondents who reported a conflict, 23 or 82% had rated therapy to be Acceptable, 3 or 11% rated it Undesirable, and 2 or 7% rated it Desirable.

Table 45 presents the data for item 47 (SNFLNC), the factor that had the most significant influence on the respondent's personal attitude towards suicide. These nominal, non-scorable data were compared with the ratings of desirability by a χ^2 test of significance. The data did not produce significant results. Most people reported professional training (38.9%) and personal philosophy (37.4%) to have influenced their attitude the most.

TABLE 44

DATA AND COMPARISON FOR ITEM 45 (CNFLCT), CONFLICT BETWEEN PERSONAL AND PROFESSIONAL ATTITUDES TOWARDS SUICIDE

Absolute Frequency Table

Desirability	Yes	No	
U	3	29	32
A	23	49	72
D	2	29	31
	28	107	135=N

2 missing cases

Comparison	d.f.	X^2	α
(DES)	2	11.86266	.0027

TABLE 45

DATA AND COMPARISON FOR ITEM 47 (SNFLNC), THE MOST SIGNIFICANT INFLUENCE ON PERSONAL ATTITUDES TOWARDS SUICIDE

Absolute Frequency Table

	Client Suicide	Suicide of Personal Friend or Family Member	Professional Training	Personal Philosophy	Reading	Other	
U	2	1	9	15	1	4	32
A	3	4	29	25	0	9	70
D	2	1	13	9	1	3	29
	7	6	51	49	2	16	131=N

6 missing observations

Comparison	d.f.	X^2	—
(DES)	10	5.63296	.8451

Analysis of Supplementary Items #29, #31, #39

There were a total of nine supplementary items included in this study. Four of them, #5, #7, #8, and #37 were already analyzed in the section on the independent variable. The results of numbers 38 and 49, openended questions not subject to any statistical analysis, will be included in the discussion section. Numbers 29, 31, and 39 will be presented here.

Table 46 presents the data for item #29 (CNSLT), the use of consultation when treating seriously suicidal clients. This item was scored from 1 to 4, higher scores indicating greater desire or perceived necessity of the use of consultation. The mean scores were compared with the ratings of desirability by ANOVA using an F test for significance. The data did not produce significance. The average means indicate that, in general, therapists do find consultation a good thing.

Table 47 presents the data for item #31 (FCNSLT), the function of consultation when treating seriously suicidal clients. These nominal data, non-scorable categories of response, were compared with the ratings of desirability (Undesirable, Acceptable, Desirable) using a χ^2 test of significance. The data did not produce significance. Over half of the respondents reported the most important functions of consultation to be the establishment of an effect-

TABLE 46

Data and Comparisons for Supplementary Item 29, (CNSLT), the Use of Consultation When Treating a Seriously Suicidal Client

Desirability	Psychiatrists	Psychologists
	$\bar{X}$ (N) (SD)	$\bar{X}$ (N) (SD)
U	2.727 (11) (.786)	2.955 (22) (.950)
A	2.333 (30) (.959)	2.837 (43) (.924)
D	2.143 (14) (.949)	2.706 (17) (.985)
	2.363 (55)	2.838 (82) N = 137

Comparisons	d.f.	F	α
(DES)	2	1.281	.281
(PSYCH)	1	7.738	.006
(DES)x(PSYCH)	2	.292	.999

TABLE 47

DATA AND COMPARISON FOR SUPPLEMENTARY ITEM 31 (FCNSLT), THE MOST IMPORTANT FUNCTION OF CONSULTATION WHEN TREATING SERIOUSLY SUICIDAL CLIENTS

Absolute Frequency Table

	Responsibility	Personal Support	Anxiety Control	Countertrans-ference Control	Treatment Plan	Other	
U	2	2	1	7	18	3	33
A	4	3	1	21	38	5	72
D	1	3	1	7	17	1	30
	7	8	3	35	73	9	135=N

2 missing observations

Comparison	d.f.	X^2	—
(DES)	10	3.4847	.9676

ive treatment plan.

Table 48 presents the data for item #39 (APP), the uniqueness of the therapeutic approach to seriously suicidal clients. The respondents could answer yes or no. The responses were compared with the ratings of desirability using a χ^2 test of significance. The data did not produce significance. A post hoc analysis produced significance at the .0522 level (the criteria for this study was $\alpha = .01$) for psychiatrists only. This suggests a non-significant trend that the more desirable a psychiatrist rated therapy with seriously suicidal clients, the more likely he was to have an aspect in his therapeutic approach to seriously suicidal clients that was unique or different from his general approach.

Multiple Regression Analysis

In recognition that this study was descriptive and explanatory in nature, an additional statistical analysis was planned that would consider more than one variable at a time. Since about half of the items were scorable, a correlation matrix was set up followed by multiple regression analysis. The multiple regression procedure helped specify which variables are important in predicting desirability, item #6 (DES), when all of the variables are considered together. This was consistent with the stated goals of this

TABLE 48

DATA AND COMPARISONS FOR SUPPLEMENTARY ITEM #((APP),
AN ASPECT OF TREATMENT UNIQUE TO
SERIOUSLY SUICIDAL CLIENTS

Absolute Frequency Tables

Psychologists

	Yes	No	
U	9	11	20
A	24	17	41
D	6	11	17
	39	39	78

Psychiatrists

	Yes	No	
U	4	7	11
A	13	17	30
D	11	3	14
	28	27	55

Comparisons	d.f.	X^2	—
Total: (DES)	2	1.2161	.5444
Psychiatrists: (DES)	2	5.9067	.0522
Psychologists: (DES)	2	2.8657	.2386

study.

Twenty-four variables that were capable of ordinal scale scoring were included in the analysis (see Table 50). The results show that, when considered together these variables can account for approximately 45% of the total variability of the ratings of desirability. This is as expected since about half of the total number of variables on the questionnaire were being considered.

The two most important variables in predicting desirability were items #37 (RWRD) and item #12 (ABLTY) which correspond to how rewarding the respondent rated therapy with seriously suicidal clients and how much ability, in terms of skill and knowledge, the respondent feels he has for treating seriously suicidal clients. The contribution of these two variables in predicting desirability, when the compounding effects of the intercorrelations between all 24 variables are considered, are significant beyond an alpha level of .01.

TABLE 49

Summary of Significant Results from Comparisons of the Ratings of Desirability with the Dependent Variables

Dependent Variables	α
Supplementary:	
Item 5, STRT	.001
Item 7, ARD	.000
Item 8, LDSRBL	.000
Item 37, RWRD	.001
Area 1:	
Item 10, RSPRV	.003
Area 2:	
Item 12, ABLTY	.001
Area 3:	
Item 14, DIFF	.005
Item 17, SGCRS	.0052 (post hoc analysis, psychologists only)
Item 19, FTIME	.002
Item 21, RISK	.001
Item 22, DIFHOSP	.004 (post hoc analysis, psychologists only)
Area 5:	
Item 2, PLCEXP	.0075
Item 35, TRAING	.001
Item 3, SEXP	.002
Area 6:	
Item 45, CNFLCT	.0027

TABLE 50

Summary Table for the Multiple Regression Analysis

Step	Variable Entered	Removed	F to Enter or Remove	Significance	Multiple R	R Square
1	RWRD, Item 37		17.02975	.000	.44235	.19568
2	ABLTY, Item 12		7.38921	.008	.52295	.27348
3	DIFHOSP, Item 22		4.96332	.029	.56924	.32290
4	STRT, Item 5		3.45626	.067	.59676	.35612
5	YREXP, Item 1		2.49203	.119	.61607	.37954
6	DIFPRV, Item 23		1.05645	.308	.62407	.38947
7	DFCHAR, Item 20		1.44596	.234	.63479	.40296
8	RISK, Item 21		.90058	.346	.64138	.41137
9	CRSTRS, Item 15		1.10019	.298	.64933	.42163
10	DIFF, Item 14		1.10671	.297	.65722	.43194
11	PRGHT, Item 46		.49615	.484	.66076	.43660
12	CNSLT, Item 29		.30106	.585	.66292	.43946
13	RSPRV, Item 10		.30138	.585	.66510	.44236
14	SOLUTION, Item 44		.43111	.514	.66824	.44654
15	CMPLS, Item 32		.24978	.619	.67007	.44900
16	STRMA, Item 26		.14202	.708	.67113	.45042
17	TRAING, Item 35		.11550	.735	.67201	.45159
18	WCT, Item 25		.14801	.702	.67134	.45312
19	DSTRMA, Item 27		.08219	.775	.67378	.45398
20	TIME, Item 18		.06079	.806	.67426	.45463
21	BLAME, Item 28		.04740	.829	.67465	.45515
22	TRHGT, Item 9		.02938	.865	.67489	.45548
23	CT, Item 24		.02466	.867	.67510	.45576
24	SEXP, Item 3		.01148	.915	.67520	.45589

C H A P T E R V

DISCUSSION OF THE RESULTS

This chapter presents a comprehensive discussion and interpretation of results. The discussion will focus first on the significant differences between the responses of psychiatrists and psychologists to the questions, then on the significant and nonsignificant results of the comparisons of the study variables with the ratings of desirability. The responses to the openended questions and other written comments will be incorporated into these discussions. From this discussion, an integrative conclusive statement will be developed and the implications of this study will be drawn.

Discussion of the Significant Differences in Sample Populations

Since each study sample is composed of responses of both psychologists and psychiatrists, the possibility exists that their responses on any one variable differed creating distortion in the interpretation of the results for the combined study samples. To increase the accuracy of interpretation, the responses of psychologists and psychiatrists were compared. The responses of scorable items of the two different therapist populations, psychologists and psychia-

trists, were compared with each other to denote six significant differences in their responses (see Table 1):

1) (STRT) Psychiatrists report treating more seriously suicidal clients in the past six months than psychologists ($\alpha = .001$).

2) (CNSLT) Psychologists report greater desirability of consultation when treating a seriously suicidal client ($\alpha = .006$).

3) (RSPRV) Psychiatrists take more responsibility for the prevention of a client's suicide than do psychologists ($\alpha = .001$).

4) (TRAING) Psychiatrists' ratings of the amount of specialized training for the treatment of seriously suicidal clients is higher than psychologists ($\alpha = .004$).

5) (SEXP) Psychiatrists' ratings of the amount of clinical experience with seriously suicidal clients is higher than psychologists ($\alpha = .004$).

6) (CMPLS) More psychiatrists have experienced more completed suicides on the average than psychologists ($\alpha = .001$).

Interpretation. The need for medication and sometimes hospitalization for seriously suicidal clients often necessitates the treatment or at least collaboration of a psychiatrist. Therefore it is not surprising that they had more clinical experience with seriously suicidal clients than psychologists (SEXP), had treated more seriously suicidal

clients in the past six months than psychologists (STRT), and thus, experienced more completed suicides than psychologists (CMPLS). In fact 76.4% of all psychiatrists had had a patient commit suicide while only 43.9% of the psychologists had had the experience.

If the role of a psychiatrist brings him into a higher amount of contact with seriously suicidal clients, it is understandable that they might have more specialized training for the treatment of seriously suicidal clients (TRAING). What is unclear is what types training this involved, i.e., medical, psychological, etc. Also, it is perhaps the professional role demands of the psychiatrist that lead him to take more responsibility for the prevention of the suicide of a client (RSPRV) as well. A comment by one psychiatrist suggests such a speculation:

> Blast. A therapist's job is to prevent suicide of psychiatrically ill people. He should use any means available to achieve this end. What's the problem? Why all the questions? Does the Ph.D. lead to more role confusion about responsibility than the M.D?

It could be speculated that the greater desirability of consultation (CNSLT) when treating a seriously suicidal client for psychologists is related to a need for medical collaboration.

Implications. Even though the differences in the responses between psychologists and psychiatrists were on some

items that were significantly related to desirability (STRT, TRAING, SEXP, RSPRV), this does not mean that psychologists and psychiatrists differ in their ratings of desirability. In fact, the differences on this variable, item #49 (PSYCH) were not significant when compared with desirability (see Table 31). These are differences in the overall responses of each profession and not differences in relation to the ratings of desirability item #6 (DES), e.g., the number of seriously suicidal clients treated in the past six months, item #5 (STRT), is greater for psychiatrists than psychologists--but also there is a trend that higher ratings of desirability are associated with a greater number of seriously suicidal clients treated for both psychologists and psychiatrists (see Table 3). The directions on the differences between means for the different levels of desirability were the same for each variable mentioned above. It was just the relative size of the means that varied.

It may be concluded that the results of the comparisons of the ratings of desirability, item #6 (DES), with the other questionnaire items may be assumed to be uniformly applicable to both professions, unless indicated to be otherwise. This conclusion is predicated on the statements in the preceding paragraph and also the following: a) None of the two way interaction effects between the ratings of desirability (Undesirable, Acceptable, Desirable) and professional identity with the scorable questionnaire study items

were significant; and b) if the data for any item, either mean scores or cell frequencies, appeared different for psychologists and psychiatrists, a post hoc analysis was performed to compare the results with the dependent variable separately. Only two such analyses proved significant.

Discussion of the Results--Ratings of Desirability

Hypothesis one. The review of the literature on the treatment of seriously suicidal clients revealed many aversive aspects of working with a suicidal client. It was often implied or stated in the literature that mental health professionals find the suicidal population very undesirable as candidates for psychotherapy, some therapists even avoid their treatment (Reubin, 1973; Farberow, 1962; Hendin, 1961; Litman, 1968). Therefore, the first goal of this research was to assess how undesirable the treatment process was rated by mental health professionals (in this case psychologists and psychiatrists), those identified as the group to deal with suicide in our society.

How desirable a therapist finds the process of psychotherapy with seriously suicidal clients was directly measured by Item #6. Table 2 presents the absolute and relative frequencies of response for the respondents. The division of the responses into the three study samples allows testing of the first experimental hypothesis: Most thera-

pists find the process of psychotherapy with seriously suicidal clients to be undesirable and prefer not to and/or avoid working with these clients. The response frequencies approximate a normal curve centering on Acceptable. Since only 33 (24.1%) respondents rated the therapy process as Undesirable compared to 73 (53.3%) Acceptable and 31 (22.6%) Desirable responses, this hypothesis is not supported. In fact, over half of the therapists seem to rate the task as Acceptable. But what does Acceptable really mean in terms of the treatment process--an accepting attitude with neither negative or positive feelings of importance, or an ambivalent attitude of conflicted positive and negative feelings? The results of the rest of this study will help clarify this question as well as distinguishing between the respondents by their different ratings of desirability.

Supplementary items 5, 7, 8, 37. These items were included to provide checks or alternative measures on the ratings of desirability for item #6, the independent variable. The data for all four variables varied significantly in the expected directions in association with the ratings of desirability of treating seriously suicidal clients. These findings support the propositions that 1) item #6 is capable of distinguishing among the three different levels of desirability of the treatment of seriously suicidal clients, and 2) the criteria used to generate the three sample populations for this study are operationally valid. Thus, justi-

fication is provided for the comparative analyses of the study samples along the dimensions of the independent variables which allows testing of the second hypothesis.

Table 3 presents the data for item #5 (STRT), a measure of how many suicidal clients the respondent has treated in the past six months. Statistical significance at the .001 level suggested a trend that the more desirable a therapist rated the task, the greater the number of clients he treated in the past six months. The raw data showed a strong similarity to the results for the dependent variable, that is, 25.7% of the respondents had treated less than one seriously suicidal client in the past six months and 24.1% rated the task Undesirable; 54.3% had treated between two and seven seriously suicidal clients and 53.3% rated the task Acceptable; and 19.8% had treated eight or more seriously suicidal clients and 22.6% rated the task as Desirable. The fact that three-fourths of the respondents reported treating two or more seriously suicidal clients in the past six months reinforces the conclusion drawn from the results of the ratings of desirability, item #6, that is, most therapists do not find therapy with seriously suicidal clients to be undesirable and do not avoid working with these clients.

Table 4 presents the data for item #7, (ARD), which records the therapist's usual practice of accepting, referring, or refusing seriously suicidal clients for therapy.

Statistical significance at the .0000 level suggested a trend that the more desirable a therapist rated the task, the more likely he was to accept a client rather than refer, or refuse the client. Also the raw data indicates that over three-fourths of the respondents accept seriously suicidal clients for therapy which reinforces the results of item #6, the ratings of desirability, that is, the majority of therapists do not find the task of therapy undesirable and do not avoid working with these clients.

Table 5 presents the data for item #8 (LDSRBL), an indication of the clinical population the respondent found least desirable. For both populations drug addicts were the least favored, alcoholics the second least favored. However, statistical significance at the .000 level suggested a trend that the lower ratings of desirability were associated with more frequent choices of seriously suicidal individuals as the least desirable client for a therapist. The low frequency of the choice of seriously suicidal clients as the least desirable (9.5%) does not support experimental hypothesis one.

Table 6 presents the data for item #37 (RWRD), a rating of how rewarding the respondent generally finds psychotherapy with seriously suicidal clients. A trend that higher ratings of desirability were found to be significantly (α = .001) associated with the perception of greater rewards in the process of therapy. A look at the raw data shows that

the mean scores for the majority of the respondents (Acceptable and Desirable combine to equal 76% of the total sample) approximate a rating of rewarding--3.000. Item #38, an openended question, was included to add depth to item #37. It asks the respondent to indicate what is for him the most rewarding, positive aspect and the most unrewarding, negative aspect of psychotherapy with seriously suicidal clients. The answers were diverse and usually brief, a large percentage about 35%, responding that it was simply a matter of success or failure, the client resolved the suicidal crisis and proceeded to self-growth or the client did not resolve the suicidal crisis and lapsed into depression, committed suicide, etc. About 20% (all desirability levels) stated or implied that dealing with the basic life and death issue, to be able to help in a life and death situation, was very challenging and satisfying to them when successful. The most frequently specified negative aspects were the emotional strain of fears, anxiety, and the intensity of the therapy (approximately 20%), the difficulty and undesirability of dealing with clients who were often manipulative, uncooperative, hostile, and/or overly dependent (approximately 20%), and the drain of one's energy and time (approximately 20% of Acceptable psychologists only). This descriptive data does not seem to be related to ratings of desirability nor does it add anything obvious to the ratings of reward on item #37. Perhaps it will be more useful in

the interpretation of the results for some of the independent variables.

Summary and conclusion of the significant results pertaining to item #6, the ratings of desirability. The first goal of this research was to find out if mental health professionals rate the process of treating a seriously suicidal client to be undesirable. The results show that most (76%) therapists, psychiatrists and psychologists, rate it to be acceptable or better. In accordance and support with this finding, it was found that seriously suicidal clients are chosen to be the least desirable of all clinic populations by less than 10% of the respondents, more than three-fourths of the therapists accept seriously suicidal clients for treatment, and most (74.1%) therapists had treated two or more seriously suicidal clients in the past six months. Finally, it appears that most therapists find the treatment process to be more rewarding than unrewarding on the average.

Discussion of the Results of Area 1-- Professional Responsibility

Area One contained three items designed to elicit opinions and information concerning the professional responsibility involved in treating seriously suicidal clients. In the writings about the treatment of suicide, it has often been stated that mental health professionals have a commit-

ment to stop self-destruction and to preserve human life (Motto, 1972; Basescu, 1965). The question of responsibility is certainly one of the most philosophically complex, legally ambiguous, and emotionally upsetting issues for therapists.

Table 7 presents the data for item #9 (TRGHT), a measure of how much responsibility a therapist takes for deciding if a seriously suicidal client has a moral right to suicide. The overall means for the combined study samples show that those with a desirability rating of Acceptable took the least amount of responsibility, which Desirable therapists assumed the most responsibility. However the difference between these means was not significantly related to the ratings of desirability. A post hoc analysis was performed to see if the higher mean score for Desirable psychiatrists differed significantly from the lower mean scores for Acceptable and Undesirable psychiatrists. Again, significance was not found.

This failure to produce significance could reflect the difficulty of answering such a question, and/or a problem of methodology. The literature describes the issue of a client's moral right to suicide as complex and complicated. In our society, one's individual rights are championed, yet a taboo against suicide exists. A philosophic attitude of permissiveness can clash with treatment goals, e.g. Litman (1968) never interviewed a therapist who expressed the idea

that the suicide of a client was acceptable philosophically or professionally. Even Motto (1972), who advocates that the therapist should take responsibility for such decisions, states that people do have the right to suicide given certain limitations.

It could easily be concluded that the question was confusing or objectionable to many of the respondents and probably inadequate to probe the complexity of the issue. Many of the written comments express such feelings, i.e., "not answerable, we don't deal in moral issues"; "loaded question. . ."; "no such concept as moral right to suicide"; "a disturbed patient in psychotherapy has no real rights"; "I don't make decisions about people's moral rights"; ". . . only a matter of mental illness." The raw data reveals that most of the respondents either take no responsibility (36.4%) or partial responsibility (38.8%). In cases of shared responsibility, the client, family, significant others, and other professionals and agencies were the most frequently mentioned choices with whom to share the responsibility.

The rejection of, or confusion about moral matters and professional responsibility, I believe, is reflected in the answers to this question and could relate to the lack of significant results when compared to the independent variable. Perhaps a more appropriate question would have been to ask if a person undergoing psychotherapy has a right to commit suicide if he chooses. The only conclusion I can

draw is that moral matters are a controversial and unsettling issue among therapists.

Table 8 presents the data for item #10 (RSPRV), responsibility for the prevention of suicide. As with item #9, the overall mean for Acceptable therapists is the lowest and Desirable therapists have the highest overall means. This time, however, the differences between the three means are statistically significant ($\alpha = .003$). The question is why would Acceptable therapists feel or want less responsibility than Undesirable and Desirable therapists?

Perhaps the lower ratings of responsibility help to make therapy for seriously suicidal clients less undesirable to those who rate the task Acceptable. Although this is strictly speculative, an accepting attitude may be an ambivalent one, not just a passive or unemotional one. Personal conflicts or professional discomfort about suicide may be hidden behind an accepting attitude for some respondents! It is possible that both the Desirable and Undesirable therapists are less ambivalent about their personal and professional feelings about suicide, the Desirable therapists being motivated to accept the risks and responsibilites of treatment while the Undesirable therapists are not motivated to do so.

Some of the written comments, although little in number, offer support for such speculation. A psychiatrist who rated treatment as Desirable wrote:

> It does distress me that there is so much emphasis on the 'right to suicide'--this can be a real 'cop-out!'. . . . The tragedy of a successful suicide is that in the vast majority of instances, if the individual lives he will choose to live provided he had help soon enough to avert the suicidal impulse at the time of the crisis. In over 30 years of work with suicidal patients I've never had a suicide in a depressed patient--it is a common illness and when treated actively and effectively, the individual does not wish to suicide. . . . Therefore I see no room whatsoever in a professional attitude for believing in a 'right to suicide'--such an individual is most likely simply untrained or unskilled and unconsciously hurtful to his patient.

Contrast this with some comments from Acceptable therapists:

> Doctor is not responsible for the patients' illness, just for providing therapy. If he does his best--no regrets.
>
> Made me uncomfortable to get in touch with how I respond to other professionals and societal pressure 'to make sure he doesn't do it' since I believe there is little can be done in a suicidal case (can't talk out of it).
>
> Makes me think more seriously about where the patient is at rather than assume that I can save everyone no matter what their intent is.
>
> I'm impotent to stop it, but I feel an ethical and personal commitment to try and help people prevent it.
>
> Reaffirmed my philosophical stance of a right to die--contrasted with the professional stance 'stop suicide so the person can have another chance to solve his problems and improve his/her life.'

Perhaps the most support for my speculation comes from the results to item #45 (CNFLCT), which recorded the exist-

ence of a conflict between professional and personal attitudes toward suicide (see Table 44). A conflict was reported more frequently among Acceptable therapists than among Desirable or Undesirable therapists. In fact, 23 of the 28 yes responses (82%) were among Acceptable therapists. In other terms 32%, or one of every three Acceptable therapists reported a conflict. Thus Acceptable therapists not only had the lowest mean average of responsibility, but also reported the greatest (82%) frequency of conflicts.

What are the implications of this speculation that some or many of the Acceptable ratings mask ambivalence and/or personal conflicts and/or professional discomfort about suicide? One implication is that the Acceptable response could be a socially desirable one in contrast to admitting the task is really Undesirable. The percentage of therapists (24.1%) who find the treatment of seriously suicidal clients to be undesirable may be higher if social desirability of responses could be controlled. A more serious implication would be that the ambivalence, conflicts, or discomfort interferred with the treatment process out of the awareness of the therapists. As stated in the Review of the Literature, a therapist must have a clear and meaningful philosophy of life and death to constructively relate to suicidal and/or depressed patients (Hammer, 1972). The direct, open and detailed discussions of the client's life and philosophy, recommended in the proper management and treatment of

a seriously suicidal client, may be inhibited by therapist fears, discomfort, etc. Therapist anxiety could lead to premature hospitalization of the client. It is doubtful that a therapist would want the responsibilities of treatment if his own attitude about death and suicide was a problem and/or an unresolved conflict.

Table 9 presents the data for item #8 (FRSP), the greatest influence on attitudes of responsibility in the treatment of seriously suicidal clients. The data were not significantly related to the independent variable. Professional role, personal philosophy, and professional experience were equally chosen by respondents. The choices of professional role and professional experience probably overlap considerably. The combined response to both of these choices accounts for 60.85% of the total response, which leads to the conclusion that professional related experiences are the most important in influencing attitudes of responsibility.

Summary of the discussion of Area 1. Therapists seem to reject and/or have difficulty with the idea of taking responsibility for deciding on a client's right to suicide. The issue is complex and perhaps requires a more probing interview type of research to study it properly.

There is evidence in the data that many of the therapists who rated therapy with seriously suicidal clients to be Acceptable have ambivalent or conflicted feelings about

it. Specifically, these therapists reported the highest amount of conflict between their personal and professional attitudes toward suicide, especially on the issues of responsibility. It is significant that Acceptable therapists took the least amount of responsibility for the prevention of suicide. Considering this and the problem of social desirability of responses, the percentage of therapists who find treatment to be undesirable, or at least professionally uncomfortable, may be higher than one-fourth of all respondents.

Finally, professional related experiences appear to be most important in influencing attitudes of responsibility.

Discussion of the Results of Area 2--Professional Ability

In the literature review, it was noted that not all therapists agree as to how much of an expertise is possible in the area of suicide management and treatment. Since the quality and amounts of professional experience and training of therapists is certain to differ, it was fairly certain that their perceptions of their ability would differ. Furthermore, it was assumed that if a therapist feels that his ability to treat seriously suicidal clients is poor or insufficient, he would probably not desire to engage in the treatment process (excepting possibly for supervised educa-

tional purposes).

Table 10 presents the data for item #12 (ABLTY), the respondents' self-rating of ability in terms of skill and knowledge to effectively manage and treat a client who is seriously suicidal. The data indicate significantly (α = .001) a trend that higher ratings of ability correspond with higher ratings of desirability (DES). Clearly, confidence in one's abilities affects the desirability of treatment.

Since ratings of ability affect desirability, it is important to know what influences the ratings of ability. Table 11 presents the data for item #13 (FABLTY). This question asks what factor contributed the most to the respondents' ability rating in question #12. No significant differences were found as a function of the dependent variable, the ratings of desirability. Examinations show that more than half of the respondents (58.8%) feel that the amount of training or professional experience they have with the task influences their ratings of ability the most! Personal characteristics as a therapist was specified by 29.4% of the respondents as most influential.

In conclusion, confidence in one's ability affects ratings of desirability and the amount of training and professional experience affects confidence in one's ability. This would seem to be an important consideration for professional training institutions as well as those professional organizations interested in the prevention of suicide. Perhaps

this seems to be just a matter of common sense, but again there has been no research on the topic of the quantity or quality of professional training and experience for the management and treatment of suicide that mental health professionals receive in the course of their professional training. Is it a part of every program? How much variation is there?

Discussion of the Results of Area 3-- Difficulties in the Treatment Process

A therapist's ability, in terms of skills and knowledge, certainly influences how difficult a task therapy will be for the therapist. However, there are aspects of the treatment situation that could make it difficult regardless of one's level of ability. Area 3 investigates difficulties of the treatment process of seriously suicidal individuals that could make it an undesirable task (a total of 13 items, Tables 12-24).

Table 12 presents the data for item #18 (DIFF), a general rating of the difficulty of treating a seriously suicidal client apart from the ability rating. The data indicated significantly ($\alpha = .005$), not surprisingly, a trend that higher ratings of difficulty were related to lower ratings of desirability of treatment (DES). The average means for each study sample corresponded to ratings of moderately

with the anxiety of a suicidal crisis. Thus, the issue of anxiety, acknowledged to be high, and its management, acknowledged to be difficult, does not appear to be related to desirability. Rather, anxiety and emotional stress seem to be a usual reaction to a suicidal crisis and an acknowledged and accepted difficulty of therapy.

Another possible explanation that does not necessarily exclude the above interpretation is that the question asked for the "general reaction." Some comments indicated that the amount of emotional stress precipitated by a client's suicidal crises and the difficulty of dealing with it are specific to individual cases depending on such circumstances as the potential for homocide, seriousness of intent, prognosis for treatment, extent of the familial or social supportive network for the client, etc. Perhaps some therapists' ratings of desirability are affected by the anxiety elicited by certain cases, but not "in general."

Table 15 presents the data for item #17 (SGCRS), the perceived significance of a client's suicidal crisis. Although the data did not produce significance when compared with the ratings of desirability, a post hoc analysis did produce significant results. The three sample populations were divided by professional identity producing three sample populations of desirability for psychologists and three separate sample populations for psychiatrists. Chi-squared tests produced significance for psychologists ($\alpha = .005$),

but not for psychiatrists (α = .508). The data thus indicate a trend that the more desirable a psychologist (but not a psychiatrist) rates psychotherapy with seriously suicidal clients, the more likely he is to perceive a suicidal crisis as a positive and important part of the therapeutic process.

Item #17 was included in the data to provide support for a speculation made by Reubin (1973). Reubin speculated from anecdotal interview material that while most psychologists experience emotional stress following an unsuccessful suicide attempt by a client, the therapeutic role of the suicidal crisis was perceived differently by those who were more willing to provide treatment to suicidal clients. While most psychologists perceived suicidal behaviors as a normal part of the therapeutic process, the "more willing" psychologists viewed a suicidal episode as providing an opportunity for their clients' increased growth, e.g. such as opening new and previously unconscious material which their clients had not been able to deal with before. Other therapists ("neutrally willing") placed less importance on crisis events and some even repressed suicidal ideation and behaviors in their clients to avoid complications in the process of therapy. My data clearly support Reubin's speculations.

The question remains why this theory of Reubin's does not seem to apply to psychiatrists. I have no anecdotal data to draw upon so my speculations are exceptionally weak.

Perhaps the medical orientation of psychiatrists, which often includes medical control of depressive symptoms through the use of drugs and ECT, is geared toward the suppression or elimination of suicidal behaviors. This question can only be answered by further research. One serious deficit of this study was an absence of questions pertaining to the medical treatment of suicide from the viewpoint of psychiatrists and psychologists.

Most writers on the treatment of suicide agree that an extra commitment of time and effort is involved (Basescu, 1964; Litman, 1957; Mintz, 1968; Rotov, 1970; Stone, 1971; Tabachnik, 1961). Table 16 presents the data for item #18 (TIME), a general rating of the extra commitment of time and effort involved in the treatment of seriously suicidal individuals. The mean scores support the literature in that most therapists do find that there is more than a medium increase in effort involved in the treatment of a seriously suicidal client. However, the data are not signiificantly related to ratings of desirability. This is easily understood when the data for item #19 is considered.

Table 17 presents the data for item #19 (FTIME), the therapists' feelings about an extra commitment of time and effort. The data indicate significantly ($\alpha = .002$) a trend that the more undesirable a respondent rates psychotherapy with seriously suicidal clients the more an extra commitment of time and energy is experienced as an inconvenience or

burden. Thus while the treatment is acknowledged to involve extra demands, some find it a burden and others do not, and this is associated with the ratings of desirability.

Why some find the extra demands of time and energy to be a burden and others do not is a question this research does not answer. However, one possible explanation is supported by other results in this study and in Reubin's (1973) research. Reubin speculated from his data that "treatment prone psychologists" find the process of therapy with seriously suicidal clients to be more rewarding than those who were not "treatment prone." They fully recognized the exaggerated demands and responsibilities, but perceive them as more challenging, exciting, and intriguing. They adjust (lower) their treatment goals to the difficulty of the case and thus obtain satisfaction from limited progress.

The results to item #38, an openended question that asked what was the most rewarding and unrewarding aspects of therapy with seriously suicidal clients, contains some similar comments. On this question 20% of the negative comments concerned the drain of energy and time and 20% of the positive comments specified that being able to help in a life and death situation was challenging and satisfying to them. The fact that these two comments occurred in large proportion is important even though the results to item #38 were not compared with the desirability. Thus, considering Reubin's speculations and the results to item #38, one pos-

sible explanation is that some respondents do not find the extra commitment of time and energy to be as much of a burden because they find therapy to be more rewarding.

Table 18 presents the data for item #20 (DIFCHAR), the difficulty of dealing with the character and/or life situation of seriously suicidal clients. The results did not produce significance when compared to the ratings of desirability, item #6. However, the overall means indicate that it is mildly to moderately difficult to deal with these clients. This is supported by the response to item #38 where 20% of the respondents specified that the most unrewarding aspect of therapy was the difficulty and undesirability of dealing with clients who were often manipulative, uncooperative, hostile, and/or overly dependent. Thus the difficulty of dealing with the character of suicidal clients, like therapist anxiety (items #7 and 8), is acknowledged as a problem, but not related to desirability.

Again, as before, non-significance may be a phenomena associated with the wording "in general." It is possible that the character of certain difficult clients has had an influence on therapists' ratings of desirability of treatment in general. After a harrowing or trying experience, a therapist could be wary of exposing himself to another such experience by avoiding all seriously suicidal clients. But, generally, this variable, item #20, does not seem to predict desirability.

Table 19 presents the data for item #21 (RISK), the difficulty of estimating suicidal risk. The data indicate significantly ($\alpha = .001$) a trend that the more difficulty a therapist has in estimating suicidal risk, the more undesirable he finds psychotherapy with seriously suicidal clients. Perhaps this variable is significantly related to desirability because of the great importance of accurately estimating the risk for suicide. Clinical decisions about treatment depend on differentiating people according to risk and there are up to an estimated 10 suicide attempts for every completed suicide (Stengel, 1964). Despite a large body of literature on diagnosis, it is still a human decision (Mintz, 1968; Shneidman, 1967; Shneidman & Farberow, 1957; Shneidman & Mandelkorn, 1970). The consequences of improperly estimating the risk of suicide for a client could be fatal!

Related to the question of estimating risk is the problem of intervention if risk is estimated to be great. The question of restraining someone for their own good is perhaps the ultimate question of responsibility. The decision to assume control over another's life, to manage another's life is a responsibility some are reluctant to make (Basescu, 1965) and one others loathe to make (Tenenbaum, 1964). Still the responsibility of intervening to help is advocated by many (Lesse, 1965; Motto, 1972). Table 20 presents the data for item #22 (DIFHOSP), the difficulty of making re-

strictive decisions for suicide prevention. The data indicated a non-significant trend (α = .028) that increased difficulty was related to undesirability. Noting the large difference between the same means for psychologists a post hoc analysis using t tests was performed. The sample mean for Undesirable psychiatrists was compared with the sample mean for Desirable psychiatrists; the same comparison was done for psychologists. Psychologists who rated psychotherapy with seriously suicidal clients as desirable found restrictive decisions significantly (α = .002) less difficult to make than those who rated it as undesirable. This was not indicated for psychiatrists (α = .525)! Thus that trend proved significant upon further analysis for psychologists, but not for psychiatrists.

Why the difference between means is not significant for psychiatrists perhaps is related to their medical orientation and their legal position in society. As noted in the comparisons of professional identity with desirability, psychiatrsts reported more specialized training for, more clinical experience with, and greater feelings of responsibility for the treatment of seriously suicidal patients. Also, commitment usually requires the legal signature of a medical doctor, usually a psychiatrist. Therefore, no matter how desirable they find it, the greater contact and legal position probably contribute to making the means for the difficulty of restrictive decisions more homogeneous for psychi-

atrists.

If the risk of suicide is estimated to be great, it may be difficult to prevent it. There is no guarantee against suicide despite therapy or restrictive decisions. Table 21 presents the data for item #23 (DIFRRV), the difficulty of preventing suicide. The data indicate a non-significant trend (α = .017) that the more desirable the respondent rates psychotherapy with seriously suicidal clients, the less difficult he finds it to prevent the client's suicide.

Perhaps the most undesirable aspect of treatment is the realistic possibility, as just mentioned above, that a seriously suicidal client may kill him/herself. But can a mistake in management or an action of the therapist, i.e., countertransference rejection, lead to the suicide of a client? Table 22 presents the data for item #24 (CT), the belief that therapist behavior can lead to the suicide of a client. Comparison with the independent variable did not produce significant results. Most important, however, is that the raw data and the average means indicate that most people believe mistakes do lead to suicide, at least infrequently to occasionally.

Table 23 presents the data for item #25 (WCT), the therapist's personal concern about making a mistake that would lead to a client's suicide. Although, on the average, the respondents expressed moderate concern, the data were not significantly related to the independent variable. The

worry of a mistake is acknowledged and apparently accepted without effecting the desirability of treatment. Perhaps the question is too general to be of use. There are many factors related to the question of transference and counter-transference. The great variation in the personalities of the therapist, in the length and quality of the client-therapist relationships, and in theoretical positions all contribute to making a judgment about therapy in general very difficult. The question may simply not have been able to probe or measure the complexity of the issue as it was related to desirability. Methodological coding aside, most therapists seem concerned, but it does not influence their ratings of desirability in general.

Associated with the difficulty of estimating the risk of suicide and having no guarantee that it can be prevented is the possibility that the therapist might be held responsible if the client did complete suicide. Table 24 presents the data for item #28 (BLAME), the vulnerability a therapist would fear if a client completed suicide. The data show that, on the average, therapists feel at least a little vulnerable to moderately vulnerable. This agrees with Litman's (1968) findings concerning blame. However, the results are not significantly related to desirability. Perhaps the keywords here are "in general," as some written comments indicated that the intensity of their feelings depended highly on the circumstances of each case individually. A possible

circumstance might include where and how the patient was being treated, i.e., hospital or outpatient, private practice or public clinic, etc. Also the use or non-use of consultation and sharing of responsibility as well as the length and quality of the treatment probably influence feelings of vulnerability and/or guilt!

Summary of the discussion of the results of Area 3. Therapists who rate therapy with seriously suicidal clients as undesirable appear to also find it more difficult in general. Specifically, the more difficulty a therapist has in estimating suicidal risk, the more undesirable he finds psychotherapy with seriously suicidal clients. Although not statistically significant, there is also a trend that ratings of desirability are related to the experienced difficulty in presenting suicide.

The treatment of seriously suicidal individuals is acknowledged by all to involve an extra commitment of time and effort and the more it is experienced as an inconvenience or burden, the more likely the therapist will rate the task undesirable. A possible explanation is that some respondents do not find the extra commitment a burden because they find therapy to be more personally rewarding.

The more desirable a psychologist, but not a psychiatrist, rated psychotherapy with seriously suicidal clients, the more likely he was to perceive a suicidal crisis as a positive and important part of the therapeutic process. One

speculative explanation of this finding is that the medical orientation of psychiatrists, which often includes medical control of depressive symptoms through the use of drugs and ECT, is geared towards the suppression or elimination of suicidal behaviors. Also psychologists, who rated psychotherapy with seriously suicidal clients as desirable found restrictive decisions significantly less difficult to make than those who rated it as undesirable. Again, questions exploring the different roles of psychologists and psychiatrists on legal and medical positions may have been helpful in explaining this difference. Therapist anxiety precipitated by a client's suicidal crisis is acknowledged to be high and its management is noted as difficult, yet, neither fact appears to be related to desirability ratings of therapy with seriously suicidal clients. Likewise, the difficulty of dealing with the character of suicidal clients is also acknowledged as a problem, but does not appear related to ratings of desirability.

Most therapists do believe that a mistake in management or an action of the therapist, i.e., countertransference rejection, can lead to the suicide of a client, at least infrequently. Most are moderately concerned about their own actions. Most would feel at least a little to moderately vulnerable to blame if a client did commit suicide. However, none of these beliefs or concerns appear to be related to ratings of the desirability of treatment. Some of the non-

significant variables may be found to influence ratings of desirability if a different research approach is used. The wording of these questions asked for a "general reaction" and therefore passed over the sometimes significant influence of individual cases.

Discussion of the Results of Area 4-- Reaction to the Completed Suicide of a Client

The completed suicide of a client in therapy is probably the most unwanted and traumatic event a therapist could encounter in his professional career. The items of Area 4 pertain to such an event to determine if the event of suicide has an effect on desirability ratings.

Tables 25 and 26 present the data for item #25 (STRMA), the amount of emotional stress a therapist feels is precipitated due to the suicide of a client and item #26 (DSTRMA), the difficulty the therapist has in dealing with this emotional stress. Neither sets of data are significantly related to the ratings of desirability (Undesirable, Acceptable, Desirable). In fact, there is little difference between the mean scores at all. The average mean scores indicate that, in general, therapists find the suicide of a client to be traumatic, at least moderately to extremely so, and it is mildly to moderately difficult to deal with this emotional stress.

It is probably the fact that these questions elicit general feelings that the data are not related to the ratings of desirability. Most writers believe that the intensity of the therapists' reaction to suicide will vary, depending on the length of therapy, the amount of professional commitment, and the closeness felt in the interpersonal relationship (Carter, 1971; Litman, 1965). The effects on desirability of therapy are probably linked to the circumstances and emotional resolution of specific cases, rather than on one's general first emotional reaction to suicides in general. Litman (1968) found some therapists had not resolved the emotional trauma of a client's death and were not willing to accept the emotional risks in the future as a part of their job. Questions more specific in nature might have elicited material similar to Litman's on the relationship between the emotional shock of suicide and ratings of desirability.

A second and perhaps more important methodological consideration is the fact that 59 or 43% of the respondents had never experienced a suicide of a client and their responses could distort the results since they could not speak from experience.

Table 27 presents the data for item #32 (CMPLS), the frequency of completed suicides for a therapist. The data showed that 78 or 57% of the respondents had one or more completed suicides in their career. However, the experience

of a suicide(s) itself was not related to desirability. Even though psychiatrists on the average experienced more, the experience in itself of a death does not seem to be related to desirability.

Table 28 presents the data for item #33 (PLCMPLS), the clinical settings in which the therapist had been treating patients who committed suicide. Almost half of the respondents, who reported one or more completed suicides, were seeing these clients in private practice; one-fourth were being seen in an outpatient clinic. The data were not related significantly to ratings of desirability. Thus, although losing a patient in a hospital setting is a different experience from that of private practice (Kahne, 1968), it does not seem to affect the ratings of desirability. The personal feelings elicited in the therapist are the same, i.e., numbness, disbelief, anger, guilt, grief, loss of confidence, etc. It is again probably the nature of a specific case and its resolution that could affect a therapist's attitudes toward future treatment.

One factor frequently mentioned in the literature as having a positive influence on the resolution of a therapist's feelings of loss and failure is the use of consultation (Carter, 1971; Litman, 1965; Reubin, 1973). Table 29 presents the data for item #30 (SCNSLT), the use of consultation to help deal with the feelings associated with the loss of a client by suicide. The data revealed that consul-

tation was sometimes used by therapists, but its use was not significantly related to desirability.

Table 30 presents the data for item #34 (SEFFECT), the effect a completed suicide(s) has on the respondent's attitude toward the treatment of seriously suicidal clients. Half (49.4%) of those who reported loss of clients by suicide reported it had a significant positive effect on their attitudes, thirty-five percent reported no significant effects, and only 10.4% reported it had a negative effect. The nature of the written comments are similar to some of those mentioned by Litman (1965) as a res lt of his interviews with therapists who had had a client commit suicide. One positive effect was that it was a learning experience for many therapists, alerting them to subtle clues, improving their judgments. Another effect mentioned was less inhibition about the use of restrictive measures and a stronger feeling that suicidal clients are an emergency. The most prominent negative effect was an increase in personal questioning and doubting of abilities and a sense of overcautiousness following the suicide of the client.

However, the results, the positive, negative or absence of effects of a suicide, were not significantly related to desirability! It is hard to believe and inconsistent with Litman's (1968) interview data that the death of a client is unrelated to desirability. Perhaps the question was not an effective or valid measure. The comments pertain mostly to

the therapy approach itself (i.e., "made me more alert to subtle cues"; "stronger stance and usefulness of consultation and hospitalization"; "work at times more cautiously") rather than their personal feelings about providing therapy. Perhaps the question should have been more specifically worded to find out if the therapists were "more likely", "less likely", or "just as likely" to provide therapy for other suicidal clients after the experience of a client's suicide.

Implications of the results. The results for all the items of Area 4 were non-significant when related to desirability. In view of the problems of asking how a completed suicide(s) affected their ratings "in general," the large number of respondents with no experience of completed suicides, the anecdotal comments, and contradictory (to the research) conclusions of Litman's research, a suggestion is offered to help direct further research into this area. Questions directed at the specific effects of specific cases might be more useful and productive in ascertaining if and what types of experiences in relation to a client's completed suicide affect future ratings of desirability. Although item #34 (SEFFECT) attempted this, I believe it was too brief and not detailed enough. Information about the kinds of feelings and eventual resolutions of any conflicts for specific cases would help. Do certain types of cases or situations lead to more adverse effects? Perhaps a ques-

tionnaire approach is entirely inappropriate for exploring this most personal and private of areas. Other researchers have met resistance when attempting to contact and interview therapists who had recently lost clients to suicide (Bloom, 1967; Litman, 1965).

Discussion of the Results of Area 5-- Professional Experience

It would be reasonable to assume that, in general, the amount and quality of a therapist's experiences as a professional would influence his attitudes toward treating seriously suicidal clients. The question is what particular experiences really do have an influence? Area 5 contains nine items which cover many different aspects of professional experience, the notable exception being the experience of completed suicides, which was covered in Area 4.

Since psychiatrists and psychologists have many different training and professional experiences, their attitudes toward the treatment of seriously suicidal clients might also be different. Table 31 presents the data for item #49 (PSYCH), the professional identity of the respondent. This item did not appear on the questionnaire, but was ascertained from a coding of the questionnaires sent to the two different sample populations. Comparison of the data with the ratings of desirability did not produce significant re-

sults. It appears that professional identity does not influence ratings of desirability. One possible explanation for this could be that the issues of importance facing the therapist in treating a seriously suicidal client are the same. This hypothesis is supported by the fact that of all the variables compared with the ratings of desirability, the results of only two of them were significantly related to desirability for just one group of the two different professions (see Table 48). In general, desirability is predicted by the same variables for both professions.

Table 32 presents the data for item #1 (YREXP), the years of professional experience the respondent has in clinical practice. A non-significant alpha level of .032 suggests a trend that the less experienced therapists find the treatment of seriously suicidal clients more desirable. This finding, although just a trend, is supported by Reubin (1973), who found in his comparison of "treatment prone" and "neutrally willing" psychologists that the "treatment prone" psychologists had fewer years of clinical experience. He believed that this result indicated that the more youthful and recently educated clinical psychologists had more opportunities for specialized training in the course of their academic careers. Indeed, one of the variables to soon be presented in this paper, the amount of specialized training, was found to be significantly related to ratings of desirability. Reubin also speculated that younger clinicians may

also have a more idealistic view of psychotherapy, guaranteeing services to all indiscriminately and/or they may have less motivation to selectively choose clientele, if they are still in the process of experimentation with therapeutic techniques and problems. However, the high average of the number of years of experience in this study as compared to Reubin's, greater than 13 years versus less than 4 years, reduces the applicability of such speculations for this study.

Table 36 presents the data for item #2 (PLCEXP), the setting in which the respondent has had m st of his clinical experience. The data did produce significant results (α = .0073) when compared with the ratings of desirability. A look at the raw data aids in interpreting this finding. The percentage of respondents, per level of desirability, that indicated they had most of their clinical experience in private practice decreases from 69.6% for Undesirable to 54.7% for Acceptable to 35.5% for Desirable. The percentage of those choosing other settings increases in the same direction from Undesirable to Desirable. Thus, a trend exists that the more undesirable a therapist rated therapy with seriously suicidal clients, the more likely he had most of his experience in private practice. Perhaps this is due to greater amounts of personal and professional support available in clinics and hospitals. In these settings the therapist can diffuse and share the responsibility and the extra

workload often associated with caring for seriously suicidal clients.

Table 37 presents the data for item #4 (SPLCEXP), the setting in which the respondent has had most of his experience with seriously suicidal clients. The data did not produce significant results (α = .0593) when compared with the independent variable. The alpha level of .0593 just fell short of indicating a trend similar to the results for item #3 (PLCEXP), that is, the more undesirable a therapist rated psychotherapy with seriously suicidal clients, the more likely he was to have had most of his clinica experience in private practice. Why is the setting of experience with seriously suicidal clients not more strongly associated with the ratings of desirability as is the setting of general clinical experience? Given that Undesirable therapists prefer not to treat suicidal clients anyhow, and in fact do not treat them as often (item #5, STRT), it is possible that they might prefer or insist to see them only in an inpatient or clinic setting when and if they do accept them for treatment.

Table 33 presents the data for item #35 (TRAING), the amount of specialized training a therapist feels he has had for the treatment of seriously suicidal clients. The data indicate significantly (α = .001) a trend that the more training a therapist feels he has had, the more desirable he finds the treatment process. This finding is supported by

the data for item #36 (PREPARE) in Table 35. This item pertains to the factor a therapist thought best prepared (or would prepare) him to deal professionally with seriously suicidal clients. Although the data were not related significantly to the ratings of desirability, professional training was chosen most often as the most important factor to prepare the therapist for psychotherapy with seriously suicidal clients.

Table 34 presents the data for item #3 (SEXP), the amount of experience the respondent reports he has had with seriously suicidal clients. The data indicate significantly (α = .002) a trend that higher ratings of desirability are related to ratings of more experience with seriously suicidal clients. The implication of this result and the results of items 35 (TRAING) and 36 (PREPARE) is that the provision of specialized training and actual clinical experience with suicidal clients decreases the undesirability of treating such clients. Training institutions as well as institutions that specialize in the prevention and treatment of suicide should make this an important consideration in their program development if they have not done so already.

Summary of the results of Area 5. The professional identity of the respondent does not appear to influence his ratings of desirability of treating seriously suicidal clients. A non-significant trend suggests that the less experienced therapists may find the treatment process of seri-

ously suicidal clients more desirable. However, a significant trend suggests that higher ratings of desirability are associated with more experience with seriously suicidal clients.

Those therapists who reported to have most of their clinical experience in private practice were more likely to rate therapy with seriously suicidal clients as undesirable. A non-significant trend suggested the same relationship between the ratings of desirability and the clinical setting in which the respondent had most of his experience with seriously suicidal individuals.

A significant trend suggested that the more specialized training a therapist feels he had for the treatment of seriously suicidal individuals the more desirable he rated therapy. Professional training was chosen most often as the most important factor to prepare a therapist for psychotherapy with seriously suicidal clients.

Discussion of the Results of Area 6-- Personal Attitudes about Suicide

The question of suicide is a value judgment of great importance in a philosophy of life. This author agrees with Hammer (1972) who believes that a therapist must have a clear and meaningful philosophy of life and death to constructively relate to suicidal and/or depressed clients.

Area 6 contains eight items designed to explore the respondents' personal attitudes about suicide.

Table 38 presents the data for item #40 (CNTMPLT), the serious contemplation of suicide. The data were not significantly related to the ratings of desirability (Undesirable, Acceptable, Desirable). Most (79.56%) respondents reported they had never seriously contemplated suicide.

Table 39 presents the data for item #41 (ATTEMPT), occurrence of an actual suicide attempt. The data were not significantly related to the ratings of desirability. Most respondents (97.45%) reported they had ne er actually attempted suicide.

Table 40 presents the data for item #42 (PRBLTY), the estimated lifetime probability of committing suicide. The data were not significantly related to the ratings of desirability. Most respondents (65%) reported they doubted they would do it under any circumstances.

Table 41 presents the data for item #43 (DIE), the occurrence of a desire for death. The data did not produce significant results in comparison with the ratings of desirability. Most (63.5%) respondents reported there had been no time in their life when they wanted to die. Of those who did say yes, 46% reported it was due to great emotional upset.

The data for items 40-43 reveal that most of the respondents have never seriously contemplated suicide (79.56%),

most doubted they would ever do it under any circumstances (65%), most have never really wanted to die for any reason (63.5%), and thus, not surprisingly, most have never attempted suicide (97.45%). The existence of suicidal behaviors is not only absent in most of the respondents' answers, but appears to be totally unrelated to their professional attitudes about the desirability of treating seriously suicidal clients. Perhaps it is not the existence of different suicidal behaviors that affect ratings of desirability, but the therapists' attitudes about suicidal behaviors in his personal life, and in particular, in contrast to his professional life. Items 44, 45, and 46 pertain to this issue.

Table 43 presents the data for item #46 (PRGHT), an individual's moral right to suicide. The data did not produce significant results in comparisons with the ratings of desirability (Undesirable, Acceptable, Desirable). The overall average score indicates that most people feel an individual does have a right to suicide, subject to limitations. The most frequently mentioned conditions for a right to suicide were: a) if a person was suffering from a terminal illness in the advanced stages of deterioration (approximately 35%); b) if the person was not mentally disturbed and the choice of suicide was neither irrational nor pathological (in 25%); c) if the person's actions would not place hardships on others, i.e., social obligations (about 15%); and d) if the person has talked over the decision with an-

other individual, professional, or personal, before coming to a definite decision (in 15%). These responses reflect Motto's (1972) opinions about the right to suicide. He states that people do have a right to suicide subject to the limitations that the act is based upon a realistic assessment of the person's life situation and not clouded by emotional or irrational distortions. The question remains of the relationship of this personal attitude to professional attitudes. The written comments to this item on a personal right to suicide were straightforward and consistent in comparison to the answers for item #9, the responsibility for deciding on a client's right to suicide. Again, this raises the question of conflict between professional role and personal beliefs.

Table 42 presents the data for item #44 (SOLUTION), the endorsement of suicide as a solution to life's problems. The data did not produce significant results in comparison with the ratings of desirability. The average of all scores indicate general agreement ("I mostly agree") that suicide is not an acceptable solution to life's problems. This is consistent with the results for item #46, when the nature of the limitations mentioned on a person's right to suicide is considered. It also is consistent with the absence of suicidal behavior noted before.

Table 44 presented the data for item #45 (CONFLCT), the existence of a conflict between personal and professional

attitudes toward suicide. Considering the results of the items in Area 6, that in an absence of suicidal behaviors in the therapist's life, a negative evaluation of suicide as a solution to life's problems, and fairly restrictive limits on the right to suicide, it is not surprising that 79.3% of the respondents did not report any conflict. The data, however, do produce significance when compared with the ratings of desirability (α = .0027). However, the form of the data of this result is different from what might be expected. Those who rated therapy with seriously suicidal clients to be Acceptable more frequently reported a onflict than those who rated it Undesirable or Desirable! Of the 28 respondents who reported a conflict, 23 or 82% had rated therapy to be Acceptable. In other terms, 32% of those who rated therapy as Acceptable, also report a conflict between personal and professional attitudes about suicide.

The written comments, mostly from those who reported a conflict, help to clarify the nature of the conflicts. Some mentioned the conflict between the professional attitude of preventing all suicides, while personally feeling there are exceptions to the rule as in the case of terminal cancer. Others, while feeling professionally obligated to prevent suicide, personally felt that each person had a right to their own decision of life and death. This was the most frequently reported conflict and the questions of responsibility were alluded to in other comments as well:

> I feel that the only suicide I should be responsible for is my own!
>
> I can't help but be influenced by the community's expectation that if I'm on the ball my clients won't suicide, despite my disapproval of suicide prevention as a professional goal.

Those who reported no conflict most often mentioned that they felt suicidal impulses were a sign of mental disturbance that would soon pass and that suicide should be prevented. To quote, "I am committed to examining all possible alternatives to suicide for myself and others." However, the existence of conflict, even though perhaps small, appeared in the writings of some who reported no conflict. For example, note the conflict in the following passage from an Acceptable psychiatrist:

> Suicide is an evasion of responsibility. . . . Suicide is. . .morally unacceptable. . . . However, if serious physical illness which prevented effective functioning were to occur. . .I could accept the decision for suicide. However, I would feel responsible to help that person, if a patient, to see potential for continued positive effect on others and to prevent the suicide.

The interpretation of the results for item #45, the existence of conflict among Acceptable therapists, was presented in the Analysis of Area 1--Professional Responsibility. Briefly reiterated, it was stated that, for some therapists, an Acceptable attitude could mask ambivalence and/or personal conflicts and/or professional discomfort about suicide, especially on the issues of responsibility. It can be

concluded that most therapists' personal attitudes toward suicide are negative in relation to their own life and not related to their ratings of the desirability of treatment, except where a conflict between personal values and professional role exists. This conflict was evidenced for Acceptable therapists only.

Table 45 presents the data for item #47 (SNFLNC), the factor that had the most influence on the respondents' personal attitude towards suicide. The data did not produce significant results when compared with the ratings of desirability. Most people reported professional training (38.9%) and personal philosophy (39.4%) to have influenced their attitude the most. Those who specified particulars about their personal philosophy most often mentioned the right to freedom of individual choice or liberties, a belief that life has value and is precious, and religious beliefs. The most frequently mentioned "other" significant influence listed by respondents was professional experience often including a belief that people work through depression.

Summary of Area 6. Most of the respondents report they have never seriously contemplated suicide, most doubted they would do it under any circumstances, most have never really wanted to die for any reason, and most have never attempted suicide. Most do not believe suicide is an acceptable solution to life's problems, yet most therapists feel an indi-

vidual does have a right to suicide, subject to limitations. None of these behaviors or attitudes appear to be related to the ratings of desirability.

There does appear to be a conflict between personal and professional attitudes towards suicide for 32% of the therapists who rated therapy with seriously suicidal clients as Acceptable. It is possible that an Acceptable rating masks ambivalence and/or personal conflicts and/or professional discomfort about suicide, especially on the issues of responsibility.

Most therapists report professional training and/or personal philosophy to have influenced their personal attitudes toward suicide the most.

Discussion of the Results of Supplementary Items #29, #31, #39

There were a total of nine supplementary items included in this study. Four of them, #5, #7, #8, and #37 were already analyzed in the section on the ratings of desirability. The results of numbers 38 and 48, openended questions not subject to any statistical analysis, were included in the interpretation of results of various independent variables when appropriate. Numbers 29, 31, and 39 will be presented here.

Litman (1965) believes that the use of consultation

during the treatment of a seriously suicidal client is important and leads to less guilt or feelings of incompetence if a suicide does occur. Table 46 presents the data for item #29 (CNSLT), the use of consultation when treating seriously suicidal clients. The average means indicate that, in general, therapists do find consultation desirable. However, the data are not significantly related to the ratings of desirability of treating seriously suicidal clients. Further research might be aimed at explaining how the actual frequency of use of consultation is related to desirability rather than just explaining how v luable therapists believe it to be.

Table #46 presents the data for item #31 (FCNSLT), function of consultation when treating seriously suicidal clients. The data did not produce significant results when compared with the ratings of desirability. Over half of the therapists reported the most important function of consultation to be the establishment of an effective treatment plan.

Table 48 presents the data for item #39 (APP), the uniqueness of the therapeutic approach to seriously suicidal clients. Half of the respondents indicated that there were aspects of their treatment approach to seriously suicidal clients that were unique or different from their general approach. Most frequently mentioned were increases in personal commitment, emotional support, time, personal sharing, involvement, activity, directiveness, restrictive measures,

and general intensity. These findings are in accordance with Litman's (1957) remarks on the approach to seriously suicidal clients.

The data did not produce significant results in comparison to the ratings of desirability (Undesirable, Acceptable, Desirable). A post hoc analysis produced a non-significant ($\alpha = .0522$) trend for psychiatrists only, that is, the more desirable a psychiatrist rated therapy with seriously suicidal clients, the more likely he was to have an aspect in his therapeutic approach to seriously suicidal clients that was unique or different from his general approach. The lack of significance (or even a trend for psychologists) suggests that the type of approach taken does not influence desirability. However, Reubin (1973) found that his "treatment prone psychologists (for suicide)" demonstrated a greater degree of commitment to all clients, not just suicidal, beyond the confines of the office. Thus, it may be that willingness to provide the extra commitment influences desirability rather than knowledge or opinion that such a commitment is needed. The results for item #19 (DTIME) support this conclusion.

Multiple Regression Analysis

Twenty-four variables that were capable of ordinal scale scoring were included in the analysis. The results

show that, when considered together these variables can account for approximately 45% of the total variability of the dependent variable (see Table 50). This is as expected since about half of the total number of variables on the questionnaire were being considered.

The two most important variables in predicting desirability were item #37 (RWRD) and item #12 (ABLTY), which correspond to how rewarding the respondent rated therapy with seriously suicidal clients and how much ability, in terms of skill and knowledge the respondent feels he has for treating seriously suicidal clients. The contribution of these two variables in predicting desirability, when the compounding effects of the intercorrelations between all 24 variables are considered, are significant beyond an alpha level of .01. The interpretation of this result is presented in the next section.

Final Summary and Conclusion

It is proper to start out with a statement of the limits of this study. The following conclusions are not intended to represent empirical conclusions. They are subjective interpretations of the results from a questionnaire, a research method that yields "expert" opinions from an adequate sampling of a professional population. While the significant (and non-significant) results of this study distin-

guish to some extent between therapists' differential ratings of the desirability of the treatment of seriously suicidal individuals, they do not adequately explain why some find it a more desirable task. It is believed that the results of this study are meaningful enough to develop tentative constructs about mental health professionals' attitudes towards the treatment of seriously suicidal individuals and to facilitate development of hypotheses for further research.

The first goal of this research was to find out if mental health professionals rate the process of treating a seriously suicidal client to be undesirab e. The results show that most (76%) therapists, psychiatrists and psychologists, rate it to be acceptable or better. In accordance and support with this finding, it was found that seriously suicidal clients are chosen to be the least desirable of all clinic populations by less than 10% of the respondents, more than three-fourths of the therapists accept seriously suicidal clients for treatment, and most (74.1%) therapists had treated two or more seriously suicidal clients in the past six months. Finally, it appears that most therapists find the treatment process to be more rewarding than unrewarding on the average.

The implications of this finding are that despite the many possible undesirable aspects of treating a seriously suicidal client both suggested in the literature and affirmed in this study, three-fourths of all therapists do not

find it to be undesirable and accept and treat these suicidal individuals.

There is evidence in the data as a whole, however, that many of the therapists who rated therapy with seriously suicidal clients to be Acceptable have ambivalent or conflicted feelings about it. Specifically, these therapists reported the highest amount of conflict between their personal and professional attitudes toward suicide, especially on the issue of responsibility. It is also significant that "Acceptable" therapists took the least amount of responsibility for the prevention of suicide. Considering this and the problem of social desirability of responses, the percentage of therapists who find treatment to be undesirable, or at least professionally uncomfortable, may be higher than one-fourth of all respondents.

In conclusion, most of the results support the proposition that therapists who find the task of treating a seriously suicidal client to be undesirable are a minority. However, one-fourth or more of all therapists do find the task undesirable and that is a large enough proportion to warrant concern for the professions of psychology and psychiatry.

The second goal of this research was to investigate which aspects of the treatment situation of those suggested by the literature contribute to making it undesirable. The third goal was to identify individual differences of profes-

sional experience and personal feelings about suicide that are associated with differential ratings of desirability of treating a seriously suicidal client. These two goals may be combined to ask the question, what predicts desirability? The multiple regression analysis suggested that how rewarding a therapist finds therapy with seriously suicidal clients and how much ability he feels he has to manage and treat a seriously suicidal client are the most important factors. An integration of the results of this study as a whole supports this conclusion.

First of all, higher ratings of ability were significantly related to higher ratings of desirability. The difficulty of estimating a client's potential as a suicidal risk (statistically significant) and the difficulty of preventing the suicide of a client (statistical trend) are other variables related to desirability that are also tasks reflecting ability. Also, ability is most often the result of professional training and experience, as reported in this study. The amount of specialized training for the treatment and the amount of clinical experience treating seriously suicidal clients were both significantly related to desirability. Finally, the most frequently reported use of consultation was to establish an effective treatment plan and professional training was reported to be the best experience for preparing a therapist to deal with seriously suicidal clients. Thus, ratings of ability affect desirability and

ratings of ability are influenced by professional training and experience.

The importance of how rewarding therapists find treatment in predicting desirability is established by its significance when compared by analysis of variance and multiple regression analysis. Its relation to other significant and nonsignificant variables requires some speculation. It was generally acknowledged by the respondents that therapy with seriously suicidal clients is difficult and emotionally stressful, often requiring a different approach involving an extra commitment of time and energy and personal involvement. How much of a burden or inconvenience the extra commitment was perceived to be by therapists was significantly related to desirability. Perhaps it is the amount of reward a therapist received from or perceives as coming from treatment that outweighs the difficulties or motivates the therapist to put up with the acknowledged difficulties. The written comments support this conclusion as well as the results of the only other related study by Reubin (1973). The perception of helping in a life and death struggle, of making a vital contribution, makes this task an important one. It is a matter of satisfaction for a set of professional values in a professional role.

Considerations for further research. The methodology of this research appears to be limited in the investigation of how certain variables are related to desirability. The

effects of a completed suicide, the emotional stress due to a client's suicidal crisis, and the concern of a mistake (countertransference) precipitating suicide are variables that might better be studied through individual, in-depth interviews. These variables are influenced highly by the specific circumstances of a particular case and may thus affect desirability in ways not detectable to questions that ask for a general response to all cases. Also, a questionnaire approach cannot individualize follow-up questions to each therapist to explore his feelings and how he handles them.

Further research might also include questions that clarify the influence of a medical orientation on psychiatrists. Other mental health professions, such as psychiatric social workers, social workers, psychiatric nurses, and pastoral counselors, might be included to further broaden the generalizability of the results.

Finally, considering the importance of the two variables of reward and ability for predicting desirability, further detailed study into the determinants of a perception of rewards from therapy with seriously suicidal clients and a study of the professional school's training programs and their influence on ability ratings might be profitable.

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APPENDIX A

The Questionnaire

1) How many years of experience do you have in clinical practice as a psychotherapist?

a) 0-5
b) 6-10
c) 11-15
d) 16 or more

2) Where have you done your clinical work up to this point in your career? (Write in approximate %)

a) Private practice____
b) Inpatient hospital setting____
c) Outpatient clinic____
d) Other_____

3) In your career, how much experience have you had with clients who you considered to be seriously suicidal? (Be specific if possible.)

a) None
b) Very little experience_____
c) An intermediate amount of experience_____
_____
d) Extensive experience_____

4) In what clinical setting have you had your experiences with seriously suicidal clients? (Write in approximate %)

a) Private practice____
b) Inpatient hospital setting____
c) Outpatient clinic____
d) Other_____

5) How many, of all the clients you have treated in the past six months, have been or are seriously suicidal in your judgment?

a) 0-1
b) 2-3
c) 4-5
d) 6-7
e) 8 or more

6) In general, how desirable do you or would you find psychotherapy with clients who are seriously suicidal?

a) Extremely undesirable, I avoid working with them.
b) Undesirable, I prefer not to work with them.
c) Acceptable.
d) Desirable, I like to work with them.
e) Very desirable, I prefer to work with them.

7) As a therapist, do you usually

a) accept seriously suicidal clients for therapy.
b) refer seriously suicidal clients for therapy elsewhere.
c) decline or refuse to accept seriously suicidal client for therapy.

8) In general, with which of the following do you find the process of psychotherapy the least desirable for you as a therapist?

a) alcoholic patients
b) drug addicts
c) psychotic patients
d) seriously suicidal patients
e) other (please specify)_____

9) In general, who should decide whether a seriously suicidal client in psychotherapy has a moral right to suicide?

a) It is totally the therapist's responsibility.
b) It is mostly the therapist's responsibility (specify who shares the rest).
c) It is only partially the therapist's responsibility (specify who shares the rest).
d) The therapist is not responsible.

10) In general, how responsible do you or would you feel for the prevention of the suicide of a client who is seriously suicidal?

a) totally responsible
b) mostly responsible (specify who shares the responsibility with you)_____
c) only partially responsible (specify who shares most of the responsibility)_____
d) not responsible.

11) What factor most determines your attitude towards responsibility in the treatment of seriously suicidal clients?

a) professional role or identity
b) personal philosophy
c) professional experience
d) other_____

12) In general, my ability (skills and knowledge) as a therapist to effectively manage and treat a person who is seriously suicidal is:

a) excellent
b) good
c) fair
d) poor

13) Which of the following contributes the most to your rating of ability?

a) The amount of training or professional experience with the task (i.e., little or extensive).
b) The ease or difficulty of the task.
c) Personal characteristics as a therapist.
d) Other_____

14) Apart from your ability level, in general, how difficult a task do you rate the process of managing and treating a client who is seriously suicidal?

a) very difficult
b) moderately difficult
c) mildly difficult
d) not difficult

15) As a therapist, I find a suicidal crisis in therapy to generally be:

a) extremely anxiety provoking and emotionally stressful.
b) moderately anxiety provoking and emotionally stressful.
c) only mildly anxiety provoking and emotionally stressful.
d) not at all anxiety provoking and emotionally stressful.

16) If you do find a suicidal crisis to be generally moderately to extremely anxiety provoking and emotionally stressful (answers a or b of the previous question), how difficult is it for you to deal with this stress?

a) very difficult
b) moderately difficult
c) mildly difficult
d) not difficult

17) A suicidal crisis in psychotherapy (increased ideation and preoccupation with suicidal thoughts, and/or an unsuccessful attempt) is most often:

a) an important part of the therapeutic process, providing a chance for increased psychological growth by the client.

b) a part of the therapeutic process, but of secondary importance for the client's progress.
c) a part of the therapeutic process, which usually complicates or interrupts the client's progress in treatment.

18) In general, how much of an extra commitment of time and effort (i.e., possible increased number and length of therapy sessions, increased therapist activity in the sessions, 24-hour availability, contact with relatives, etc.) do you find is usually (or would you imagine is) involved in the treatment of a seriously suicidal client?

a) a large increase in effort
b) a medium increase in effort
c) a small increase in effort
d) no extra effort

19) If you answered either a, b, or c for the last question, do you find that, in general, the extra commitment of time and effort is:

a) usually an inconvenience or burden.
b) sometimes an inconvenience or burden.
c) rarely an inconvenience or burden.
d) not at all an inconvenience or burden.

20) Suicidal clients are often described as hostile, manipulative, or to be suffering with horrendous life problems that can demoralize a therapist, etc. In general, how difficult a task do you, or would you, find it to be to deal with the character and/or life situation of most high risk suicidal clients?

a) very difficult
b) moderately difficult
c) mildly difficult
d) not difficult

21) As a therapist, how difficult do you, or would you, find it to estimate a client's potential as a suicidal risk?

a) very difficult
b) moderately difficult
c) mildly difficult
d) not difficult

22) In general, how difficult do you, or would you, find it, as a therapist, to make decisions about restrictive measures (such as hospitalization) in preventing suicide?

a) very difficult
b) moderately difficult
c) mildly difficult
d) not difficult

23) In general, how difficult do you, our would you, find the task of preventing the suicide of a seriously suicidal client?

a) very difficult
b) moderately difficult
c) mildly difficult
d) not difficult

24) Do you believe that a mistake in management or that an action of the therapist (i.e., countertransference rejection) could lead to the suicide of a client?

a) Yes, it probably happens a lot.
b) Yes, it happens occasionally.
c) Yes, but it is an infrequent or rare occurrence.
d) No.

25) In general, how much concern do you, or would you, have as the therapist of a seriously suicidal client, that a mistake in management or that an action of yours (i.e., countertransference rejection) could lead to the suicide of the client?

a) great concern
b) moderate concern
c) little concern
d) no concern

26) In general, the suicidal death of a client is or would be most often for you as a therapist:

a) very emotionally stressful.
b) moderately emotionally stressful.
c) mildly emotionally stressful.
d) not stressful at all.

27) In general, how difficult is it (or would it be) for you to deal with the emotional trauma you experience over the suicide of a client?

a) very difficult
b) moderately difficult
c) mildly difficult
d) not difficult

28) In general, how vulnerable to blame, public or professional, do you or would you feel as the therapist of a client who committed suicide?

a) quite vulnerable
b) moderately vulnerable
c) a little vulnerable
d) not vulnerable at all

29) When treating a client who is seriously suicidal, consultation is:

a) always necessary, or at least highly desirable.
b) usually necessary and/or desirable.
c) sometimes necessary and/or desirable.
d) rarely necessary and/or desirable.

30) If you have had a client(s) commit suicide while in your care, did you use consultation (or some other type of help, psychotherapy, etc.) to help deal with your own feelings?

a) Yes, always.
b) Sometimes.
c) No, never.

31) What do you feel is the most important function of therapist consultation in the treatment of seriously suicidal clients?

a) To share or diffuse responsibility.
b) To provide personal support for the therapist's involvement with the case.
c) To help control therapist anxiety.
d) To decrease the possibility of a mistake or countertransference on the part of the therapist.
e) To help with the establishment of an effective treatment plan.
f) Other (please specify)_____

32) In your career, how many clients of yours have committed suicide?

a) 0
b) 1
c) 2-3
d) 4 or more

33) In what clinical setting were you seeing those clients who committed suicide?

a) private practide (#)
b) outpatient clinic (#)
c) hospital or other inpatient setting (#)
d) other_____

34) If you have lost a client(s) did his/her (their) death(s) have a significant effect on your attitude towards the treatment of seriously suicidal clients?

a) Yes, a positive one._____
_____
b) Yes, a negative one._____

c) No significant effect.
d) Other _____

35) How much and what kind of specialized or specific training experiences have you had for dealing with seriously suicidal clients?

a) a large amount _____
b) an intermediate amount _____
c) not much training _____
d) none

36) What experience do you think best prepared (or would prepare) you as a therapist to deal with seriously suicidal clients?

a) Personal experience with suicide.
b) Professional experience with suicide.
c) A sound personal philosophy of life, including a view of suicide.
d) Professional training.
e) Good personal mental health.
f) Other _____

37) In general, do you usually find psychotherapy with seriously suicidal clients to be:

a) very rewarding
c) rewarding
c) unrewarding
d) very unrewarding

38) What is the most unrewarding, negative, and the most rewarding, positive aspect of psychotherapy with seriously suicidal clients?

a) rewarding _____
_____
b) unrewarding _____
_____

39) Is there any aspect of your treatment approach to seriously suicidal clients that is unique or different from your general approach with most of all your clients?

_____
_____
_____

40) Have you ever seriously contemplated committing suicide?

a) Yes
b) No

41) Have you ever actually attempted suicide?

a) Yes b) No

42) How would you estimate your lifetime probability of committing suicide?

a) In certain circumstances, I might very well do it.
b) I doubt I would do it under any circumstances.

43) Has there been a time in your life when you wanted to die?

a) Yes, because of great physical pain.
b) Yes, because of great emotional upset.
c) Yes, to escape intolerable social or interpersonal situations.
d) Yes, because of great embarrassment.
e) Yes, other_____
_____
f) No.

44) In general, suicide is unnecessary, unpleasant, and unjustified. It is a poor solution to life's problems and should not be considered a viable philosophical choice.

a) I totally agree.
b) I mostly agree.
c) I mostly disagree.
d) I totally disagree.

45) Is there any conflict or difference between your personal and professional attitudes towards suicide? (Please specify).

a) Yes_____
_____
b) No_____
_____

46) I believe a person has a right (moral, not legal) to commit suicide. . .

a) if they choose to do so, without limitation.
b) if they choose to do so, with some minor limitations (specify)_____
c) if they choose to do so, with some major limitations (specify)_____
d) under no conditions.

47) What has had the most influence on your personal attitudes towards suicide?

a) Suicide of a client.
b) Suicide of a personal friend or family member.
c) Professional training.
d) Personal philosophy (specify) _____
_____
e) Specific reading (specify) _____
_____
f) Other _____
_____

48) What effect, if any, has the questionnaire had on you? Please write any comments you wish to make.

APPENDIX B

Letters of Introduction to the Questionnaire

The Commonwealth of Massachusetts
University of Massachusetts
Amherst 01002

DEPARTMENT OF PSYCHOLOGY

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Dear Sir:

The enclosed questionnaire is part of a study being conducted by myself, Robert Crago, a graduate student in the clinical psychology program at the University of Massachusetts/Amherst. I am requesting your anonymous participation in a study that seeks information about how psychiatrists and clinical psychologists feel about the treatment process of clients who present a serious risk of suicide.

This questionnaire is being sent to a very limited sample of professionals who provide therapy. Therefore, your response is of the utmost importance for success of this study. You may have had little experience in the treatment of suicidal individuals, or be currently involved in little direct clinical work (as opposed to teaching, research, consultation, administration, etc.). However, this study desires the responses of qualified professionals with different levels of experience and backgrounds. Your anonymous cooperation and personal honesty in filling out this brief questionnaire will be gratefully appreciated.

In answering the questionnaire, please circle the response choice which most closely corresponds to your own feelings and experiences. Please feel free to write any additional responses or comments on the last page of the questionnaire.

If you desire a brief summary of this study and its findings, please send your name and full address on a post card. I expect to have the results compiled by the end of the calendar year.

Thank you for your time and cooperation.

Sincerely,

B. Robert Crago

Enclosures

Introductory Comments

As author of this study, I would like to state that I'm conscious of the limitations of this questionnaire. The questionnaire does not offer the opportunity for you to personally elaborate or explain your answers, sometimes oversimplying or overstating your own complex reactions. (I greatly welcome all who would donate their valuable time to elaborate their responses, but will be grateful if you just fill out the questionnaire.) Secondly, the questionnaire asks for your general overall response to questions about the treatment of "seriously suicidal people," that is, people who in your judgment are a serious risk for suicide. Obviously, your responses vary across individual cases. Finally, some people may feel that a few of the questions are too direct or bold and touch on sensitive issues. I hope that you will also find them thought provoking and can understand their value. Thank you again for your cooperation!

If, for some reason you cannot or will not fill out this questionnaire, please specify the reason below and return it in the self-addressed and stamped envelope enclosed. This will help control for sample bias.

_____ I've never been involved in clinical work at all.

_____ I refuse to donate my time.

_____ Other (please specify)_____

APPENDIX C

Follow-up Postcard Letter

Dear Sir:

In the past month you received a letter requesting your anonymous participation in a study that seeks information about how clinical psychologists and psychiatrists feel about the treatment process with clients who are a serious risk for suicide. If you have already filled out the questionnaire, I thank you for your cooperation in making this study a success.

Since the questionnaire was sent to a limited sample of professionals, each individual response is of the utmost importance for the completion of the study. If you have not responded yet, I hope you will do so soon.

Thank you for your cooperation.

B. Robert Crago

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